

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Paul D. Nagy, M.S., C.S.A.C.
Consensus Panel Chair
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
DHHS Publication No. (SMA) 94B2077. Printed 1994.

Table of Contents

- [\[Front Matter\]](#)
- [Chapter 1 -- Introduction](#)
- [Chapter 2 -- Placement Criteria and Expected Treatment Outcomes](#)
- [Chapter 3 -- Components of an Effective IOT Program](#)
- [Chapter 4 -- Staffing Issues and Guidelines](#)
- [Chapter 5 -- The Treatment Needs Of Special Groups](#)
- [Chapter 6 -- Special Fiscal and Administrative Issues](#)
- [Chapter 7 -- Legal Issues for IOT Programs](#)
- [Appendix A -- References](#)
- [Appendix B -- Sample IOT Program Schedules](#)
- [Appendix C -- Federal Resource Panel](#)
- [Appendix D -- Field Reviewers](#)
- [Exhibits](#)

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

[Front Matter]

[Title Page]

Tip 8: Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series 8

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
Rockwall II, 5600 Fishers Lane
Rockville, MD 20857
DHHS Publication No. (SMA) 94B2077
Printed 1994

Disclaimer

This publication is part of the Substance Abuse Prevention and Treatment Block Grant technical assistance program. All material appearing in this volume, except quoted passages from copyrighted sources, is in the public domain and may be reproduced or copied without permission from the Center for Substance Abuse Treatment (CSAT) or the authors. Citation of the source is appreciated.

This publication describes just one approach to, or model of, intensive outpatient treatment. Research and evaluation of this approach are needed, particularly with respect to its application in the public sector.

This publication was written under contract number ADM 270-91-0007 from the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA). Anna Marsh, Ph.D., and Sandra Clunies, M.S., served as the CSAT Government project officers. Randi Henderson, Mim Landry, Christopher Phillips, and Deborah Shuman served as writers.

The opinions expressed herein are the views of the consensus panel members and do not reflect the official position of CSAT or any other part of the U.S. Department of Health and Human

Services (DHHS). No official support or endorsement of CSAT or DHHS is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized patient care and treatment decisions.

DHHS Publication No. (SMA) 94B2077.

Printed 1994.

What Is a TIP?

CSAT Treatment Improvement Protocols (TIPs) are prepared by the Quality Assurance and Evaluation Branch to facilitate the transfer of state-of-the-art protocols and guidelines for the treatment of alcohol and other drug (AOD) abuse from acknowledged clinical, research, and administrative experts to the Nation's AOD abuse treatment resources.

The dissemination of a TIP is the last step in a process that begins with the recommendation of an AOD abuse problem area for consideration by a panel of experts. These include clinicians, researchers, and program managers, as well as professionals in such related fields as social services or criminal justice.

Once a topic has been selected, CSAT creates a Federal resource panel, with members from pertinent Federal agencies and national organizations, to review the state of the art in treatment and program management in the area selected. Recommendations from this Federal panel are then transmitted to the members of a second group, which consists of non-Federal experts who are intimately familiar with the topic. This group, known as a non-Federal consensus panel, meets in Washington for 5 days, makes recommendations, defines protocols, and arrives at agreement on protocols. Its members represent AOD abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A chair for the panel is charged with responsibility for ensuring that the resulting protocol reflects true group consensus.

The next step is a review of the proposed guidelines and protocol by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the chair approves the document for publication. The result is a TIP reflecting the actual state of the art of AOD abuse treatment in public and private programs recognized for their provision of high quality and innovative AOD abuse treatment.

This TIP, titled *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse*, describes the level of care that is provided by intensive outpatient treatment (IOT) programs and the range of services and service components that are included in such programs. Practical information for staffing IOT programs and for addressing clinical challenges that arise in the IOT setting is provided. The treatment needs of special groups, such as women and ethnic and cultural minorities are addressed. Improving the quality of services in IOT programs is discussed and suggestions for obtaining public and private funding are presented. A separate chapter addresses legal issues.

This TIP represents another step by CSAT toward its goal of bringing national leadership to bear in the effort to improve AOD abuse treatment.

Consensus Panel

Chair:

Paul D. Nagy, M.S., C.S.A.C.

Director

Duke Alcoholism and Addictions Program

Clinical Associate

Department of Psychiatry

Duke University Medical Center

Durham, North Carolina

Facilitators:

J.B. Bixler

Executive Director

Association of Community Mental

Health Authorities of Illinois

Springfield, Illinois

Christine L. Kasser, M.D.

Medical Director

Baptist Recovery Center

Memphis, Tennessee

Mary E. McCaul, Ph.D.

Director

Comprehensive Women's Center

Francis Scott Key Medical Center

Johns Hopkins Hospital

Baltimore, Maryland

Larry G. Osmonson, N.C.A.C. II, C.A.P., C.T.R.T.

President

National Association of Alcoholism and Drug Abuse Counselors

Workgroup Members:

L. Worth Bolton, M.S.W., A.C.S.W.

Program Director

Westhaven Outpatient Treatment Programs

Raleigh, North Carolina

Bill B. Burnett, M.Ed.

Director

Treatment and Intervention

South Carolina Commission on Alcohol and Drug Abuse

Bruce Carruth, Ph.D., L.C.S.W.

Private Practice

Little Rock Psychotherapy Group

Little Rock, Arkansas

Doris Derrington

Consultant

Alcohol and Drug Abuse Services

Topeka, Kansas

Robert F. Forman, Ph.D.

Executive Director

Rehab After Work

Fitzgerald Mercy Hospital

King of Prussia, Pennsylvania

Marco E. Jacome, C.S.A.D.C., C.E.A.P., N.C.A.C. II

Executive Director

Healthcare Alternative Systems, Inc.

Chicago, Illinois

Gary Q. Jorgensen, Ph.D.

Director

Drug and Alcohol Abuse Clinic

School of Medicine

University of Utah

George Kolodner, M.D.

Medical Director

Kolmac Clinic

Silver Spring, Maryland

Jewell Oates, Ph.D.

Executive Director

The Women's Treatment Center

Chicago, Illinois

Philip Spivey, Ph.D.

Director

Outpatient Services

Smithers Alcoholism Treatment and Training Center

St. Luke's-Roosevelt Hospital

New York, New York

Foreword

The Treatment Improvement Protocol Series (TIPs) fulfills CSAT's mission to improve alcohol and other drug (AOD) abuse and dependency treatment by providing best practices guidance to clinicians, program administrators, and payers. This guidance, in the form of a protocol, results from a careful consideration of all relevant clinical and health services research findings,

demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates employs a consensus process to produce the product. This panel's work is reviewed and critiqued by field reviewers as it evolves.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. I am grateful to all who have joined with us to contribute to advance our substance abuse treatment field.

Susan L. Becker

Associate Director for State Programs

Center for Substance Abuse Treatment

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Chapter 1 -- Introduction

These are times of change and complex challenges for professionals who work in the alcohol and other drug (AOD) abuse treatment field. They are experiencing increasingly intense pressure to provide comprehensive, cost efficient, and high quality care for AOD abuse patients. Government policies appear to be shifting away from a predominant focus on interdiction and toward an emphasis on prevention and treatment. Yet, only limited, overextended, and diminishing resources are available to provide treatment. These changes and challenges are occurring during a time when AOD disorders and their treatment are both increasing in complexity.

As a result, treatment providers are challenged to search for and consider innovative, measurably effective, and less costly approaches to the treatment of people with AOD use disorders. These challenges occur within the context of an evolution in health care policy and changes in the national health care system. Managed care and managed competition are now potent forces in health care and are likely to be important aspects of health care reform. At this time, the long-term impact of yet-to-be-established national health care policies on AOD treatment is unknown. Thus, in the face of advanced complexity of AOD use disorders, treatment professionals can expect to continue to be charged with providing treatment that achieves a balance between cost efficiency and clinical efficacy.

As AOD abuse treatment professionals examine issues of treatment effectiveness and cost, they are growing increasingly aware of the need to provide specialized treatment services for special groups. A few of the many groups that may benefit from special and often complex treatment services include:

- Persons with combined psychiatric and AOD use disorders
- Ethnic and cultural minority group members
- Persons who are homeless or experiencing housing instability
- Clients with the HIV virus or AIDS
- Gay and lesbian clients
- Pregnant women
- Elderly persons

- Those who are involved with the criminal justice system.

A number of these groups are the focus of other TIPs that readers may wish to refer to for an in-depth discussion of the particular problems and treatment of these groups.

One of the most useful responses to the challenges that face treatment providers has been the development of continuum-of-care models that match specific levels of treatment with the individual patient's particular treatment needs. Until recently, two models dominated the field of alcohol and other drug abuse treatment:

- The medically managed 28-day inpatient treatment program, and
- The low-intensity, traditional outpatient service model, which usually offers one weekly session of individual or group therapy.

A critical look at the traditional use of these two models has led to the recognition of a significant gap in the AOD treatment delivery system. In many instances, clients receive too few treatment services and are underserved; others receive more treatment services than they need. In both cases, clients receive the only level of care that is available or that they are able to find.

Further, the treatment of AOD use disorders has historically been fragmented in several ways. For instance, clients often receive a burst of intensive inpatient treatment followed by low-intensity aftercare services that are inadequate and insufficient. Also, patients who require multiple treatment services often must obtain these services at different treatment sites. For example, it is common for patients with combined psychiatric and AOD use disorders to receive psychiatric treatment at one site and AOD abuse treatment at another. Thus, AOD clients in vulnerable conditions often have to accept undue responsibility for coordinating their own care.

One of the responses of AOD abuse treatment providers to these challenges has been the development of the intensive outpatient treatment (IOT) level of care. IOT actually refers to a range of types of organized care. While it is a less intense level of care than inpatient care, IOT nonetheless provides a substantial range of treatment intensity. This level of care has been adapted to several models such as day treatment and evening programs. The IOT level of care is designed to bridge the gap between medically managed or medically monitored intensive inpatient treatment and traditional outpatient services of low intensity.

Although programs that provide AOD abuse treatment at an intermediate level of care have existed to some degree for several years, the widespread development and study of these programs has only recently gained momentum. Pressures from insurance and managed care companies, as well as demands from many sources for more cost-effective publicly funded treatment, have contributed to the growth of IOT programs.

The development and study of IOT programs are complicated by a remarkable variation in the intensity and scope of treatment services provided by IOT programs and a lack of standardization regarding quality of care measures. Standardization of the names and descriptions of intensive outpatient treatment programs does not exist. For instance, some intensive outpatient day treatment programs describe themselves as partial hospitalization programs, while other

programs that provide precisely the same services simply call themselves IOT programs. Similarly, there is wide variation in the extent of coverage for intensive outpatient treatment by third-party payers. The variation in coverage by third-party payers may be related to the variations found among IOT programs.

While the need for programs that provide an intermediate level of care seems obvious, the need for program evaluation is less obvious but equally critical. There have been fairly consistent findings of similar patient outcomes for inpatient and outpatient treatment across a range of measures -- findings that support the further development and study of intensive outpatient treatment. Unfortunately, there has not been an organized effort to identify the particular benefits of IOT or to determine the specific elements of IOT that lead to successful outcomes. This Treatment Improvement Protocol (TIP), based on the experience of members of a national multidisciplinary consensus panel, is an initial effort toward meeting such an objective.

The Purpose of This TIP

There is a need for education about IOT among AOD treatment providers, payers, and people who make referrals for AOD treatment. This TIP provides an introductory review of IOT, documenting the clinical viability and utility of IOT, and stressing the range in IOT services within the broader continuum of care. This TIP describes the rationale for the development, institutionalization, and study of the IOT level of care. It identifies the roles of IOT in relation to the other levels of care, and reviews appropriate and existing patient admission and placement criteria. It describes the essential and desirable components of an effective IOT program. It reviews salient staffing issues and needs associated with IOT programs. Finally, this TIP addresses the special issues and challenges associated with IOT, including the needs of special groups, legal and ethical issues, quality improvement challenges, and reimbursement issues.

The same forces and challenges that have prompted the development of the IOT level of care have promoted a greater awareness of the need for all health care programs to increase cooperation, collaboration, and functional linkages. AOD treatment programs are using assertive case management models to closely monitor patients' treatment across the continuum of care and through multiple service delivery systems. Indeed, AOD treatment programs are increasingly providing a greater range of services and are coordinating closely with other programs that address the needs of AOD clients.

Various challenges, including a heightened accountability to payers, have prompted the development of specific diagnostic and patient placement criteria for assessing the appropriate level of care for patients in AOD treatment settings. Patient placement criteria are instrumental in determining the optimal points for the transfer of patients from one level of care to another. The emphasis given here to intensive outpatient treatment does not suggest that traditional levels of care for AOD disorders are without purpose or efficacy.

IOT programs have gained a reputation for effectively treating highly functioning patients with relatively intact family systems and good psychosocial supports. It must be considered that many of these patients are achieving recovery and experiencing qualitative improvement in their lives not in spite of being treated in IOT programs but rather because of the distinct qualities and

advantages of IOT programs. These successes suggest that IOT programs can effectively treat a wide variety of patients who were previously considered treatable only in inpatient settings.

Advantages of IOT Programs

The IOT level of care has several clinical and consumer advantages. For instance, the cost of IOT treatment is often less than half the cost of inpatient treatment. As a result, IOT treatment is often measured in months rather than days or weeks. This allows patients more time to learn new behaviors, participate in self-help groups, and practice relapse prevention strategies. In an IOT program, patients can continue to function in already-established roles with minimal disruption to work and family life. In fact, work and family life are better stabilized through the support and structure offered by IOT.

The intensity of the IOT level of care promotes close bonding among patients. Access to the world outside of the program increases opportunities to practice learned behaviors and new responses such as drug refusal skills, open communication, and stress reduction techniques. Patients who participate in treatment within a therapeutic setting while returning daily to their home environment can practice relapse prevention techniques in the milieu in which they live. These patients can also be assessed more accurately with regard to their problems and progress. There is a greater opportunity for treatment providers to strengthen patients' psychosocial supports and to intensively intervene within their family systems.

Some IOT programs provide access to noninstitutional housing such as apartments or houses near the program site. Others operate in conjunction with a residential treatment option. In shared housing arrangements, patients experience a milieu similar to the natural living environment. They experience greater responsibility than they would in an institutional setting such as a hospital.

Underlying Principles Of the TIP

Several principles serve as the foundation for this TIP. In turn, these principles can be incorporated into the philosophy and management of IOT treatment programs.

- **Treatment works.** The suggestions, recommendations, and shared experiences that are presented in this TIP are based on the premise and documented empirical evidence that therapeutic clinical interventions have a significant impact on AOD use disorders.
- **A continuum of care will cost-effectively enhance patient care.** The treatment of patients within a continuum of care is the most cost-effective response to the treatment of AOD use disorders. The organized use of a continuum-of-care treatment system allows patients to be matched to the level of treatment they need, with precise transitional services available to meet the changing needs of individual clients. A true continuum of care should allow for longer-term care for clients who need it.
- **A multidisciplinary approach is vital.** A multidisciplinary approach to the assessment and treatment of patients with AOD use disorders is essential to good patient care. AOD-dependent patients often have several complex problems. The expertise and involvement of specialists from several disciplines are critical for positive patient outcomes. Similarly, a large repertoire of

treatment skills and techniques is required to respond to the complex and changing needs of patients.

- **Staff should be cross-trained.** Despite the need for specialists in various areas, treatment providers should encourage cross-training of staff. Despite dissimilar training backgrounds, clinical staff should share a common treatment and recovery philosophy. Staff education is essential, and programs should schedule regular times for the review and discussion of books and articles on AOD use and treatment, including published research.
- **Integration of treatment is essential.** It is no longer acceptable to treat one problem at a time and simply refer untreated issues to another provider. Rather, it is essential that treatment be integrated, and that patients receive appropriate care for existing and anticipated addiction, psychiatric, and medical problems. They must also receive the additional support services necessary to achieve problem resolution. Case management services are an important component of AOD treatment. Such services are a particularly important aspect of providing a continuum of care and integrating treatment and other services for IOT patients.
- **Treatment should be individualized.** No single approach to AOD treatment will work for all patients. Rather, treatment should be individualized for each patient, with special treatment goals to meet the particular needs of each patient. AOD treatment should involve a wide variety of clinical interventions.
- **Treatment programs should be accountable.** Treatment interventions and decisions should be based on proven, empirically supported outcomes. The optimal care of patients requires a high level of accountability. Models of treatment should be based on proven outcomes, and placement decisions should be based on known rather than assumed benefits to patients.

Overview of the TIP

[Chapter 2 -- Placement Criteria and Expected Treatment Outcomes](#)

This chapter defines IOT as a level of treatment and a range of services and intensities that exists in the context of the larger continuum of care. Within the IOT level of care, several different program models can be adapted to numerous settings. The chapter provides a review of these levels of care, a detailed description of the IOT level of care, an overview of admission and placement criteria, and dimensions for assessment based on the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* developed by the American Society of Addiction Medicine ([Hoffman et al., 1991](#)). This chapter highlights the importance of individualized treatment planning and the use of specific treatment goals.

[Chapter 3 -- Components of an Effective IOT Program](#)

To provide a balanced perspective on IOT, this chapter includes a discussion of the rationale for IOT, as well as the advantages, disadvantages, and challenges faced by IOT programs. The chapter describes treatment services that, although not proven to be essential, can be considered core elements of IOT programs, and treatment services that can be considered optimal elements of an enhanced IOT program. Common clinical issues such as retention and relapse are discussed.

Chapter 4 -- Staffing Issues and Guidelines

This chapter provides an overview of human resource issues and program needs associated with an IOT level of care. There is a discussion of the recommended professional qualities of staff members. Guidelines for clinical competency, such as skills for evaluation, counseling, and family therapy and knowledge about self-help resources, case management, and crisis management are outlined. There is also a description of ethical guidelines, professional education standards, staffing level guidelines, and staff stressors. The chapter also recommends specific ways that IOT can be designed to support treatment staff members.

Chapter 5 -- The Treatment Needs of Special Groups

This chapter describes the treatment needs of some special groups, including women, cultural and ethnic groups, homeless people, gay men and lesbians, people with HIV or AIDS, elderly patients, persons in the criminal justice system, and patients with combined psychiatric and AOD use disorders.

Chapter 6 -- Special Fiscal and Administrative Issues

The TIP includes a discussion of financial issues related to public and private funding, managed care, and program costs. There is also a discussion of quality improvement issues, including guidelines for program evaluation.

Chapter 7 -- Legal Issues for IOT Programs

The final chapter describes some common legal concerns associated with IOT, many of which have ethical implications. There is an overview of the Federal laws and regulations protecting the rights to privacy of people seeking or receiving AOD treatment services. Rules governing the use of consent forms are discussed. This chapter reviews the rules for communicating with others about AOD patients, including how agencies communicate with one another and how programs can warn others of a patient's threat to harm. Exceptions that permit programs to disclose information are described, and practical information about patients' right to confidential services and the use of legal guidance is provided.

Summary

The development of the IOT level of care is a partial response to many of the changes taking place in the addiction treatment field and throughout the national health care system. This TIP was written to provide information about the IOT level of care; to educate providers, payers, and others about the appropriate use of IOT; to encourage further development of IOT; and to assist IOT providers to evaluate and improve their programs. It is the hope of the consensus panel that this TIP and the further development of IOT will help target the level of care to patients' needs, rather than expecting patients to adapt to levels of care that are more or less intense than required. IOT is a valuable, cost-effective, and clinically effective segment of the continuum of care for AOD use disorders. It is hoped that this document will serve as an impetus toward the further demonstration of the efficacy of a continuum of care and a multidisciplinary approach to the treatment of AOD disorders.

Your browser does not support JavaScript

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Chapter 2 -- Placement Criteria and Expected Treatment Outcomes

The treatment of alcohol and other drug (AOD) use disorders can be understood as a spectrum of treatment options with differences in setting, type and range of services, and number of services used.

The severity of AOD use disorders differs among patients. Indeed, the severity of an individual's AOD disorder will fluctuate over the course of time. Since patients have a range of treatment needs, there is a corresponding need for a range of treatment options. The goal of AOD treatment is to place patients in the appropriate level of care, to match the intensity of service to the severity of illness, and to select the services needed to meet patients' individual needs.

Description of IOT

Levels of Care

Levels of care reflect both service intensity and setting. Within the context of AOD treatment, the term *treatment setting* describes the characteristic environmental features needed in the various levels of care. Treatment *intensity* refers to the scope and frequency of service provision and the number of resources utilized in providing such services.

What are the levels of care? How should clients be matched to an appropriate level of care? At what point should clients be moved from one level of care to another? To provide effective AOD treatment, answers to these questions must be understood.

It is apparent that objective placement criteria -- such as the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* ([Hoffman et al., 1991](#)) Care needed. These criteria describe in detail the different levels of care and provide specific guidelines for patient placement decisions. Although not empirically evaluated, these guidelines were developed through extensive collaboration with providers, payers, and other addiction experts and were published by the American Society of Addiction Medicine (ASAM). The guideline development

process included a review of the AOD treatment literature and extensive field testing. The criteria continue to be reviewed and studied.

In addition to the criteria developed by ASAM, States and other agencies and groups may have their own guidelines regarding levels of care. For example, the Addiction Group of the American Psychiatric Association is establishing AOD abuse treatment guidelines that can be considered by intensive outpatient treatment (IOT) programs when clarifying placement criteria. Not all patients will neatly fit into any one set of guidelines, a fact that should be weighed when considering placement criteria. The ASAM guidelines are recognized in this TIP because of their broad acceptance and application.

The overall intent of patient placement guidelines is to place a person in the least intensive level of care that will achieve AOD treatment objectives without sacrificing safety or security. The ultimate goals of the guidelines are to improve the effectiveness of care, to ensure access to affordable care, and to support the development of cost-effective treatment systems. They are also an attempt to establish patient placement criteria that are acceptable to all treatment providers and payers. They support efforts to establish a common language for AOD abuse treatment, to agree on consistent placement decisions, and to provide a focus for future research efforts. These criteria should be considered dynamic, not fixed. Future revisions are likely to be driven by research results and further review and application in the field.

Goals of Patient Placement Guidelines

- Improve quality of care
- Ensure access to affordable care
- Support development of cost-effective treatment systems.

Four levels of care for AOD abuse treatment are described in ASAM's patient placement criteria as follows:

- **Level I** -- Outpatient treatment
- **Level II** -- Intensive outpatient treatment
- **Level III** -- Medically monitored intensive inpatient treatment
- **Level IV** -- Medically managed intensive inpatient treatment.

The guidelines describe *outpatient treatment* as an organized nonresidential treatment service or an office practice with designated addiction professionals and clinicians providing professionally directed AOD treatment. This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups.

Intensive outpatient treatment (which includes partial hospitalization) is a planned and organized service in which addiction professionals and clinicians provide several AOD treatment service components to clients. Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 treatment hours per week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences.

Medically monitored intensive inpatient treatment can be described as an organized service conducted by addiction professionals and clinicians who provide a planned regimen of around-the-clock professionally directed evaluation, care, and treatment in an inpatient setting. This level of care includes 24-hour observation, monitoring, and treatment. A multidisciplinary staff functions under medical supervision. An example is a program with 24-hour nursing care under the direction of physicians.

Medically managed intensive inpatient treatment is an organized service in which addiction professionals and clinicians provide a planned regimen of 24-hour medically directed evaluation, care, and treatment in an acute care inpatient setting. Patients generally have severe withdrawal or medical, emotional, or behavioral problems that require primary medical and nursing services.

It should be noted that several AOD treatment service models do not precisely fit within the four levels of care described here. These service levels include halfway houses and extended residential programs such as therapeutic communities. These programs are designed for people who do not have housing, who experience housing instability, or who lack an organized support system. These programs are often used in conjunction with IOT or inpatient treatment.

This TIP focuses on the second level of care -- IOT. Much like AOD abuse treatment in general, IOT represents a continuum of services that range from less to more intensive treatment. Thus, IOT can be described as a range of services within the larger range of AOD treatment services. Some of the services provided are withdrawal management, group therapy, relapse prevention training, individual counseling, family counseling, and pharmacotherapy.

IOT should not be described solely by the number of contact hours per week. Because of the number of services that are provided, the contact hours at IOT programs may range from a minimum of several hours (often described as about 9 hours) to 70 or more hours per week. Further, minimal requirements for IOT may vary by State law or regulation. Since IOT involves a structured therapeutic environment combined with living at home or in a therapeutic residence, IOT affords clients an opportunity to interact with the real world environment while benefiting from a structured program in a therapeutic milieu.

Whatever the level of care being provided, AOD treatment programs should provide services that reflect the treatment needs of the patients and should modify services according to cultural, demographic, and geographic differences.

Models and Examples

The emphasis in AOD treatment should be on a flexible intensity of service delivery that

corresponds to the changing intensity of illness, not merely on a specific model of AOD treatment. As clients' treatment needs change, treatment intensity should change accordingly. Different models of treatment can be adapted to various levels of service intensity. Some IOT programs operate as day treatment programs. These models vary widely and include programs that offer AOD treatment from early morning to early evening, for 6 or 7 days per week. These programs can treat patients with significantly severe illness.

Some programs offer as few as 2 or 3 treatment contact hours daily. Some IOT programs operate as evening programs with treatment hours that range from 9 to 20 hours per week. Some IOT programs operate primarily as weekend programs. Programs that provide few hours per week may best benefit those who have meaningful social supports and are highly motivated for treatment and recovery or who have progressed through more intensive levels of care. Programs can be designed to gradually reduce the number of patient contact hours as certain treatment goals are met.

In some IOT programs, clients live at home. In other IOT programs, they live in a homelike environment in special housing or leased apartments. These programs may involve minimal to moderate supervision during nontreatment hours. For instance, some programs have a designated residence manager who participates in residence group meetings, including therapeutic, daily living, and recreational group meetings. In other programs, a residence manager lives with the patients.

An IOT program can be established in association with a homeless shelter or within the confines of a prison. IOT programs may exist within hospital settings and may include various degrees of medical management. The intensity of IOT services can be adapted to various sites and models. However, the IOT level of care is not synonymous with the site of the service.

Clearly, there are several types of IOT programs that differ in intensity because of the differences in services provided. Compared with inpatient treatment, IOT is often (but not always) less intense but is generally provided for longer periods of time.

Clients should be exposed to at least a minimum core of didactic information and receive skill enhancement in several areas before they are discharged to a different level of care. Ideally, clients should experience measurable behavioral, cognitive, and affective changes that will support abstinence and recovery. These changes occur as the result of therapeutic and psychoeducational efforts.

Irrespective of the specific model, IOT should be individualized and open-ended. Lengths of stay and placement decisions should be based on the progress of patients -- specifically, on the attainment of their individualized treatment goals. Treatment programs and treatment decisions should not be based on rigid and standardized lengths of stay. Although the educational curriculum components of AOD treatment may be based on a rotating cycle of a specific number of weeks or months, the treatment process itself should be driven exclusively by the needs of patients.

Assessment and Placement Issues

AOD Abuse Screening

The processes of screening, assessment, and diagnosis of AOD use disorders are not synonymous. An AOD *abuse screening instrument* is a tool used to identify clients who have a high probability for AOD use disorders. It is used to determine whether a diagnostic assessment is needed. For example, the CAGE questionnaire, which consists of four questions, has demonstrated a fairly high validity. The Michigan Alcohol Screening Test (MAST) and the Substance Abuse Subtle Screening Inventory (SASSI) are other widely used screening instruments that have proven useful. The ideal screening tool identifies most people with the disorder and will not select many people without the disorder. Screening tools identify people who require further diagnostic evaluation.

An AOD screening tool is generally a brief, rapidly administered tool that identifies clients who likely have an AOD problem. An AOD *diagnosis* is the confirmation of the existence of a specific AOD use disorder. The AOD diagnosis is determined by an AOD *assessment*, which is a multidimensional evaluation that appraises the severity and course of the disorder and identifies clients' strengths, weaknesses, and individual needs. The assessment is the basis of the treatment plan.

Steps in Determining AOD Use Disorders

- Screening: Identifies persons likely to have an AOD use problem.
- Assessment: Evaluates identified persons for specific AOD use disorders.
- Diagnosis: Confirms existence of a specific AOD use disorder.

AOD Abuse and Dependence

Diagnostic assessment for IOT placement begins with a diagnostic evaluation based on the criteria for substance-related disorders described in the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994) or other standardized criteria. The DSM-IV describes criteria for diagnosing substance abuse and substance dependence. Three or more of the criteria described in [Exhibit 2-1](#) must be present at any time in the same 12-month period in order to diagnose substance dependence.

There are circumstances when information about a patient's AOD use history is inadequate to substantiate the diagnosis of an AOD use disorder. In these situations, information obtained from collateral sources such as family members and legal guardians can be used to indicate a high level of probability of the diagnosis.

Dimensions for Assessment

Assessment should be an ongoing process that: 1) determines the level of care required at entry, 2) identifies patients' individual problems, 3) determines subsequent modification of treatment intensity, 4) determines to what extent patients are progressing toward the attainment of treatment goals, and 5) identifies the changes patients have made following planned interventions or treatment. Assessment is a continual process, not a single event. An assessment facilitates level-of-care decisions and determines what goals are included in individualized treatment plans. (See the TIPs *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents and Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*.)

Clinicians who assess clients must have specialized training in the assessment process. They should have the skills to effectively engage clients and to assess their potential for withdrawal and other biomedical and psychiatric problems. They should be competent to identify clients who require further medical or psychiatric assessment. Assessments should include information from observations of the client and from collateral sources and a history of previous treatment.

The primary purpose of an assessment is to provide a basis for the selection of the most appropriate treatment for the individual being assessed. To be as useful as possible, assessments should have certain features that enhance the value of the assessment information. Ideally, information gathered during an assessment should be quantitative, reliable (reproducible), valid (measures what it purports to measure), standardized (comparable to an established baseline), and recordable.

Assessments in IOT settings should be comprehensive and multidimensional. Six dimensions of illness have been described in the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* ([Hoffman et al., 1991](#)):

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional and behavioral conditions or complications
- Treatment acceptance and resistance
- Relapse potential
- Recovery environment.

Within each dimension, the ASAM guidelines list specific assessment criteria that help determine the appropriate level of care for patients. [Exhibit 2-2](#) provides an overview of the adult admission criteria described in the ASAM guidelines. It is an approximate summary to illustrate the principal concepts and structure of the criteria. These assessment criteria do not represent the only assessment dimensions: others can be considered. For example, a client's developmental history and past treatment history can be useful in making patient placement decisions.

Assessing clients by using these six dimensions facilitates comprehensive and ongoing assessment and treatment planning. Based on an initial assessment, the level of care is determined, problem areas are identified, and a treatment plan is immediately initiated. The relationships between the six dimensions of illness and placement in an IOT level of care are

briefly described below.

Acute intoxication or withdrawal potential. Patients who have severe withdrawal syndromes usually should be treated in an inpatient setting, although many of these patients may be safely managed in IOT with appropriate medical resources. Studies indicate that patients with minimal risk of severe withdrawal can be safely treated in an IOT setting with appropriate medical supervision and support from patients' significant others ([Hayashida et al., 1989](#)).

Biomedical conditions and complications. Serious medical complications necessitate inpatient treatment, but medical problems may often be managed in IOT programs or through linkages with health care providers.

Emotional and behavioral conditions or complications. Clients who require a protective environment or a 24-hour structure due to severe emotional or behavioral conditions or other complications should be treated in an inpatient setting. For placement in IOT, clients should be assessed as being in little danger of harming themselves or others. A wide range of emotional and behavioral problems can be safely and effectively managed in IOT programs -- as long as the problems are included in the treatment plan.

Treatment acceptance and resistance. Clients vary with regard to recognition and awareness of the presence and severity of their AOD use disorders and with regard to their acceptance of or resistance to treatment. To be appropriate for IOT, clients must at least agree to participate in treatment, even if they do not have a commitment to recovery. For example, as clinicians utilize motivational enhancement therapies, clients may initially attribute AOD-related problems to others or to external circumstances; ultimately, they may accept personal responsibility for these problems and for recovery.

Relapse potential. Relapse is not a single event but a process that can be interrupted at various points. AOD relapse includes ruminations about AOD use and cravings. It includes high-risk behaviors, including actual AOD use. Patients in IOT may experience AOD craving. However, patients with a persistent and severe lack of impulse control may require a more intense level of care such as inpatient treatment.

Many clients who experience AOD craving with subsequent use may nonetheless be effectively managed in IOT programs. When it occurs, the relapse experience can often be used as an effective therapeutic tool for further relapse prevention training. Relapse can often prompt the active use of learned but as yet unused or unpracticed relapse prevention and coping skills. For example, AOD use may be an opportunity for clients to reexamine their drug hunger triggers and to modify their coping strategies.

Recovery environment. Elements of the recovery environment that may indicate a need for inpatient treatment include a chaotic family with severe conflicts, AOD use within the family or living situation, and physical, sexual, or severe emotional abuse. Other elements that suggest poor matching for the IOT level of care include logistical problems such as lack of transportation or inadequate childcare. However, most AOD treatment clients experience some level of family

or social dysfunction, which can generally be addressed in IOT.

Patients whose work potentially puts the public at risk (such as pilots, bus drivers, and physicians) may experience job restrictions, but are nonetheless potential candidates for IOT.

In order to participate in IOT, the basic food and housing needs of clients should be met. For some clients, meeting these basic needs may involve linkages to social services. Some clients may become engaged in AOD treatment because case management increases the availability of basic services.

Patient Transition From One Level to Another

Like any specific level of AOD treatment, IOT may not fully meet all patients' needs. Rather, IOT is a part of the larger continuum of services. As the treatment needs of patients change, clinicians should make recommendations for their transition from one level of care to another. (See [Exhibit 2-2](#) for a summary of assessment criteria for decisions about level of care.)

To make appropriate treatment recommendations, clinicians must have a thorough understanding of all available treatment resources. Thus, all clinicians and programs that provide AOD treatment and referral services should maintain and regularly update a list of all local and regional AOD and mental health treatment services. This list should also include social service programs, vocational rehabilitation programs, health care resources, churches, self-help programs, and other forms of support such as legal or financial resources. In other words, all AOD programs and clinicians should maintain a thorough and current list of services that can help meet the biopsychosocial and spiritual needs of patients. Ideally, AOD treatment providers will have formal or familiar relationships with community agencies that are most likely to provide needed services.

Clinicians often make referrals to a small group of personally known contacts. Instead, they should carefully identify the specific needs of each client and diligently seek treatment resources that can meet those needs. Clinicians should actively initiate and broaden their contacts with other treatment providers both within and outside of AOD treatment. To create effective and complete networks of health care services, such contacts should include medical, psychiatric, social, and vocational services. Appropriate consents should be secured early in the treatment process to ease communication between separate nonaffiliated treatment providers.

Since the IOT level of care is one component of the larger continuum of care, it is necessary to adequately document treatment services and to provide this documentation to the patient's next care provider. This is necessary to improve the quality of care and to ensure efficient utilization of health care resources.

As described in the following [chapter](#), family and significant others should be part of the treatment process, participating in family sessions and education. With the patient's consent, family members should participate in treatment decisions such as those involving transitions from one level of care to another. Family members and significant others should participate in and be knowledgeable about components of the treatment plan. They can be an important source

of support for the patient during the recovery process.

Treatment Goals

The assessment process identifies specific problems that the clinical team and the client need to address and resolve. Thus, *treatment goals* are the expected therapeutic outcomes that are manifested in observable and measurable changes in behavior. Some of the treatment goals are immediate, some are long term, and others are lifetime goals. Thus, some treatment goals will be met during IOT, while others may be met during later phases of treatment and beyond. Also, treatment goals change over time, as progress is demonstrated.

While there are general treatment goals that are shared by most clients, clients will also have distinctive treatment goals that are based on their individualized needs as determined by a multidimensional, multidisciplinary assessment. Posttreatment goals and interventions should also be addressed in the treatment plan. Discharge planning begins with intake and placement and is a process that culminates in meeting minimal criteria for treatment outcome goals.

AOD treatment goals can be organized according to the six dimensions of illness described in ASAM's patient placement criteria.

Withdrawal Potential

The treatment goal relative to AOD withdrawal is an absence or reduction of the severity of the acute withdrawal syndrome so that intensive medical management is no longer needed. Some patients may have subacute or protracted withdrawal symptoms that are not severe enough to require medical management or to interfere with recovery.

Biomedical Conditions and Complications

For clients in an IOT level of care, biomedical treatment goals include the stabilization of medical problems so that medical monitoring is not required or so that the patient can receive medical management through another service provider. The treatment goal is to resolve biomedical problems enough to allow transition to a lower level of care. For example, severe hypertension can be stabilized with appropriate medication so that intensive monitoring is no longer required.

The following are examples of treatment goals in the area of biomedical problems and complications. These goals may be achieved during IOT. When these goals are unmet during IOT, a treatment plan to achieve them may be initiated during IOT and included as part of the continuing care plan.

- The patient will obtain a personal physician.
- The patient will identify any outstanding medical and dental problems and establish a plan for treatment.
- The patient will develop a personal plan for health maintenance.

- The patient will develop a personal plan for wellness.

Emotional and Behavioral Conditions or Complications

For patients in an IOT level of care, emotional or behavioral treatment goals include the stabilization of problems so that intensive management is not required or so that problems may be adequately managed through another service provider.

Based on specific emotional or behavioral problems identified through a multidisciplinary and multidimensional assessment, the treatment goal is the resolution of problems sufficient to allow a transition to a lower level of care. For example, symptoms of depression may be improved through pharmacotherapeutic intervention so that intensive monitoring is no longer required.

The following are examples of treatment goals in the area of emotional and behavioral problems. These goals may be achieved during IOT, or a treatment plan may be initiated and included as part of the continuing care plan.

- The patient's emotional and behavioral conditions will diminish in severity so that intensive management is no longer necessary.
- The patient is able to appropriately express and process emotions. The patient has learned to recognize, label, and express emotions.
- The patient can identify and discuss feelings of shame and guilt associated with AOD use. The patient can recognize the association between AOD use and personal shame and guilt issues.
- The patient can identify problems that may require ongoing psychotherapeutic support and identify a plan for obtaining such support.
- The patient has learned anger management and impulse control techniques.
- The patient has learned cognitive techniques to diminish symptoms of depression.
- The patient has learned assertiveness skills.

Treatment Acceptance and Resistance

For patients in an IOT level of care, treatment goals that relate to the issues of treatment acceptance and resistance include: 1) awareness and self-recognition of the AOD use disorder and its consequences, 2) recognition of the severity of the AOD use disorder, and 3) a personal acceptance of the AOD problem and the general goals of AOD treatment.

The following are examples of treatment goals in the area of the acceptance of or resistance to treatment. These goals may be achieved during IOT, or a treatment plan may be initiated and included as part of the continuing care plan.

- The patient recognizes his or her inability to control the use of AODs.
- The patient accepts personal responsibility for recovery.
- The patient understands the association between negative consequences and continued use of AODs.
- The patient recognizes that his or her relationship with AODs is self-defeating.

Relapse Potential

Remaining abstinent from all drugs including alcohol is a usual goal for patients in AOD treatment. For patients in an IOT level of care, treatment goals regarding relapse potential include the integration of relapse prevention skills into their behavior in such a way that they can continue their recovery process without intensive treatment or intervention. For example, a patient may routinely call his or her 12-step sponsor and attend the first available meeting after an episode of stress or craving. Generally, these treatment goals include awareness, early identification, and management of progressive relapse signs, as well as early intervention planning for relapse.

The following are examples of treatment goals in the area of relapse potential. These goals may be achieved during IOT, or through a treatment plan initiated and included as part of the continuing care plan.

- The patient understands the relationship between triggers, craving, and relapse.
- The patient has identified personal triggers for AOD craving and use.
- The patient has developed, integrated, and internalized skills and strategies for coping with triggers and high-risk situations.
- The patient has stopped participating in high-risk behaviors and activities and has discontinued high-risk relationships.
- The patient has developed AOD-refusal skills.

Recovery Environment

For patients in an IOT level of care, the treatment goals that relate to recovery environment include either improvements in the patient's environment that are sufficient to support an ongoing recovery process or acquisition of skills that are sufficient to cope successfully with a problem environment.

The following are examples of treatment goals in the area of the recovery environment. These goals may be achieved during IOT or initiated and included as part of the continuing care plan.

- The patient will develop living habits that promote abstinence and recovery.
- The patient will develop community supports that specifically promote abstinent behavior and a healthy lifestyle.
- The patient will develop the skills necessary to establish and maintain close interpersonal relationships.
- The patient will learn strategies and skills that enhance personal socialization.
- The patient will develop a plan for educational or vocational improvement as necessary.
- The patient will develop a spiritual or moral environment.
- The patient will plan for structured participation in a 12-step recovery program or a reasonable alternative.
- The patient will develop a plan for sustaining family recovery and achieving positive family relationships.
- The patient will identify community resources that may provide assistance for recovery.

A Final Thought

In many ways, this TIP chapter describes ideal patient placement decisions. In practice, however, clinical issues may not be as neatly presented and organized. Also, limited resources may restrict or interfere with the opportunity to adhere to these or other guidelines. Thus, the reader is advised to apply these or other guidelines to his or her own treatment setting and to use them in ways that are most applicable.

Your browser does not support JavaScript

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Chapter 2 -- Placement Criteria and Expected Treatment Outcomes

The treatment of alcohol and other drug (AOD) use disorders can be understood as a spectrum of treatment options with differences in setting, type and range of services, and number of services used.

The severity of AOD use disorders differs among patients. Indeed, the severity of an individual's AOD disorder will fluctuate over the course of time. Since patients have a range of treatment needs, there is a corresponding need for a range of treatment options. The goal of AOD treatment is to place patients in the appropriate level of care, to match the intensity of service to the severity of illness, and to select the services needed to meet patients' individual needs.

Description of IOT

Levels of Care

Levels of care reflect both service intensity and setting. Within the context of AOD treatment, the term *treatment setting* describes the characteristic environmental features needed in the various levels of care. Treatment *intensity* refers to the scope and frequency of service provision and the number of resources utilized in providing such services.

What are the levels of care? How should clients be matched to an appropriate level of care? At what point should clients be moved from one level of care to another? To provide effective AOD treatment, answers to these questions must be understood.

It is apparent that objective placement criteria -- such as the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* ([Hoffman et al., 1991](#)) Care needed. These criteria describe in detail the different levels of care and provide specific guidelines for patient placement decisions. Although not empirically evaluated, these guidelines were developed through extensive collaboration with providers, payers, and other addiction experts and were published by the American Society of Addiction Medicine (ASAM). The guideline development

process included a review of the AOD treatment literature and extensive field testing. The criteria continue to be reviewed and studied.

In addition to the criteria developed by ASAM, States and other agencies and groups may have their own guidelines regarding levels of care. For example, the Addiction Group of the American Psychiatric Association is establishing AOD abuse treatment guidelines that can be considered by intensive outpatient treatment (IOT) programs when clarifying placement criteria. Not all patients will neatly fit into any one set of guidelines, a fact that should be weighed when considering placement criteria. The ASAM guidelines are recognized in this TIP because of their broad acceptance and application.

The overall intent of patient placement guidelines is to place a person in the least intensive level of care that will achieve AOD treatment objectives without sacrificing safety or security. The ultimate goals of the guidelines are to improve the effectiveness of care, to ensure access to affordable care, and to support the development of cost-effective treatment systems. They are also an attempt to establish patient placement criteria that are acceptable to all treatment providers and payers. They support efforts to establish a common language for AOD abuse treatment, to agree on consistent placement decisions, and to provide a focus for future research efforts. These criteria should be considered dynamic, not fixed. Future revisions are likely to be driven by research results and further review and application in the field.

Goals of Patient Placement Guidelines

- Improve quality of care
- Ensure access to affordable care
- Support development of cost-effective treatment systems.

Four levels of care for AOD abuse treatment are described in ASAM's patient placement criteria as follows:

- **Level I** -- Outpatient treatment
- **Level II** -- Intensive outpatient treatment
- **Level III** -- Medically monitored intensive inpatient treatment
- **Level IV** -- Medically managed intensive inpatient treatment.

The guidelines describe *outpatient treatment* as an organized nonresidential treatment service or an office practice with designated addiction professionals and clinicians providing professionally directed AOD treatment. This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups.

Intensive outpatient treatment (which includes partial hospitalization) is a planned and organized service in which addiction professionals and clinicians provide several AOD treatment service components to clients. Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 treatment hours per week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in special residences.

Medically monitored intensive inpatient treatment can be described as an organized service conducted by addiction professionals and clinicians who provide a planned regimen of around-the-clock professionally directed evaluation, care, and treatment in an inpatient setting. This level of care includes 24-hour observation, monitoring, and treatment. A multidisciplinary staff functions under medical supervision. An example is a program with 24-hour nursing care under the direction of physicians.

Medically managed intensive inpatient treatment is an organized service in which addiction professionals and clinicians provide a planned regimen of 24-hour medically directed evaluation, care, and treatment in an acute care inpatient setting. Patients generally have severe withdrawal or medical, emotional, or behavioral problems that require primary medical and nursing services.

It should be noted that several AOD treatment service models do not precisely fit within the four levels of care described here. These service levels include halfway houses and extended residential programs such as therapeutic communities. These programs are designed for people who do not have housing, who experience housing instability, or who lack an organized support system. These programs are often used in conjunction with IOT or inpatient treatment.

This TIP focuses on the second level of care -- IOT. Much like AOD abuse treatment in general, IOT represents a continuum of services that range from less to more intensive treatment. Thus, IOT can be described as a range of services within the larger range of AOD treatment services. Some of the services provided are withdrawal management, group therapy, relapse prevention training, individual counseling, family counseling, and pharmacotherapy.

IOT should not be described solely by the number of contact hours per week. Because of the number of services that are provided, the contact hours at IOT programs may range from a minimum of several hours (often described as about 9 hours) to 70 or more hours per week. Further, minimal requirements for IOT may vary by State law or regulation. Since IOT involves a structured therapeutic environment combined with living at home or in a therapeutic residence, IOT affords clients an opportunity to interact with the real world environment while benefiting from a structured program in a therapeutic milieu.

Whatever the level of care being provided, AOD treatment programs should provide services that reflect the treatment needs of the patients and should modify services according to cultural, demographic, and geographic differences.

Models and Examples

The emphasis in AOD treatment should be on a flexible intensity of service delivery that

corresponds to the changing intensity of illness, not merely on a specific model of AOD treatment. As clients' treatment needs change, treatment intensity should change accordingly. Different models of treatment can be adapted to various levels of service intensity. Some IOT programs operate as day treatment programs. These models vary widely and include programs that offer AOD treatment from early morning to early evening, for 6 or 7 days per week. These programs can treat patients with significantly severe illness.

Some programs offer as few as 2 or 3 treatment contact hours daily. Some IOT programs operate as evening programs with treatment hours that range from 9 to 20 hours per week. Some IOT programs operate primarily as weekend programs. Programs that provide few hours per week may best benefit those who have meaningful social supports and are highly motivated for treatment and recovery or who have progressed through more intensive levels of care. Programs can be designed to gradually reduce the number of patient contact hours as certain treatment goals are met.

In some IOT programs, clients live at home. In other IOT programs, they live in a homelike environment in special housing or leased apartments. These programs may involve minimal to moderate supervision during nontreatment hours. For instance, some programs have a designated residence manager who participates in residence group meetings, including therapeutic, daily living, and recreational group meetings. In other programs, a residence manager lives with the patients.

An IOT program can be established in association with a homeless shelter or within the confines of a prison. IOT programs may exist within hospital settings and may include various degrees of medical management. The intensity of IOT services can be adapted to various sites and models. However, the IOT level of care is not synonymous with the site of the service.

Clearly, there are several types of IOT programs that differ in intensity because of the differences in services provided. Compared with inpatient treatment, IOT is often (but not always) less intense but is generally provided for longer periods of time.

Clients should be exposed to at least a minimum core of didactic information and receive skill enhancement in several areas before they are discharged to a different level of care. Ideally, clients should experience measurable behavioral, cognitive, and affective changes that will support abstinence and recovery. These changes occur as the result of therapeutic and psychoeducational efforts.

Irrespective of the specific model, IOT should be individualized and open-ended. Lengths of stay and placement decisions should be based on the progress of patients -- specifically, on the attainment of their individualized treatment goals. Treatment programs and treatment decisions should not be based on rigid and standardized lengths of stay. Although the educational curriculum components of AOD treatment may be based on a rotating cycle of a specific number of weeks or months, the treatment process itself should be driven exclusively by the needs of patients.

Assessment and Placement Issues

AOD Abuse Screening

The processes of screening, assessment, and diagnosis of AOD use disorders are not synonymous. An AOD *abuse screening instrument* is a tool used to identify clients who have a high probability for AOD use disorders. It is used to determine whether a diagnostic assessment is needed. For example, the CAGE questionnaire, which consists of four questions, has demonstrated a fairly high validity. The Michigan Alcohol Screening Test (MAST) and the Substance Abuse Subtle Screening Inventory (SASSI) are other widely used screening instruments that have proven useful. The ideal screening tool identifies most people with the disorder and will not select many people without the disorder. Screening tools identify people who require further diagnostic evaluation.

An AOD screening tool is generally a brief, rapidly administered tool that identifies clients who likely have an AOD problem. An AOD *diagnosis* is the confirmation of the existence of a specific AOD use disorder. The AOD diagnosis is determined by an AOD *assessment*, which is a multidimensional evaluation that appraises the severity and course of the disorder and identifies clients' strengths, weaknesses, and individual needs. The assessment is the basis of the treatment plan.

Steps in Determining AOD Use Disorders

- Screening: Identifies persons likely to have an AOD use problem.
- Assessment: Evaluates identified persons for specific AOD use disorders.
- Diagnosis: Confirms existence of a specific AOD use disorder.

AOD Abuse and Dependence

Diagnostic assessment for IOT placement begins with a diagnostic evaluation based on the criteria for substance-related disorders described in the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994) or other standardized criteria. The DSM-IV describes criteria for diagnosing substance abuse and substance dependence. Three or more of the criteria described in [Exhibit 2-1](#) must be present at any time in the same 12-month period in order to diagnose substance dependence.

There are circumstances when information about a patient's AOD use history is inadequate to substantiate the diagnosis of an AOD use disorder. In these situations, information obtained from collateral sources such as family members and legal guardians can be used to indicate a high level of probability of the diagnosis.

Dimensions for Assessment

Assessment should be an ongoing process that: 1) determines the level of care required at entry, 2) identifies patients' individual problems, 3) determines subsequent modification of treatment intensity, 4) determines to what extent patients are progressing toward the attainment of treatment goals, and 5) identifies the changes patients have made following planned interventions or treatment. Assessment is a continual process, not a single event. An assessment facilitates level-of-care decisions and determines what goals are included in individualized treatment plans. (See the TIPs *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents and Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*.)

Clinicians who assess clients must have specialized training in the assessment process. They should have the skills to effectively engage clients and to assess their potential for withdrawal and other biomedical and psychiatric problems. They should be competent to identify clients who require further medical or psychiatric assessment. Assessments should include information from observations of the client and from collateral sources and a history of previous treatment.

The primary purpose of an assessment is to provide a basis for the selection of the most appropriate treatment for the individual being assessed. To be as useful as possible, assessments should have certain features that enhance the value of the assessment information. Ideally, information gathered during an assessment should be quantitative, reliable (reproducible), valid (measures what it purports to measure), standardized (comparable to an established baseline), and recordable.

Assessments in IOT settings should be comprehensive and multidimensional. Six dimensions of illness have been described in the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders* ([Hoffman et al., 1991](#)):

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional and behavioral conditions or complications
- Treatment acceptance and resistance
- Relapse potential
- Recovery environment.

Within each dimension, the ASAM guidelines list specific assessment criteria that help determine the appropriate level of care for patients. [Exhibit 2-2](#) provides an overview of the adult admission criteria described in the ASAM guidelines. It is an approximate summary to illustrate the principal concepts and structure of the criteria. These assessment criteria do not represent the only assessment dimensions: others can be considered. For example, a client's developmental history and past treatment history can be useful in making patient placement decisions.

Assessing clients by using these six dimensions facilitates comprehensive and ongoing assessment and treatment planning. Based on an initial assessment, the level of care is determined, problem areas are identified, and a treatment plan is immediately initiated. The relationships between the six dimensions of illness and placement in an IOT level of care are

briefly described below.

Acute intoxication or withdrawal potential. Patients who have severe withdrawal syndromes usually should be treated in an inpatient setting, although many of these patients may be safely managed in IOT with appropriate medical resources. Studies indicate that patients with minimal risk of severe withdrawal can be safely treated in an IOT setting with appropriate medical supervision and support from patients' significant others ([Hayashida et al., 1989](#)).

Biomedical conditions and complications. Serious medical complications necessitate inpatient treatment, but medical problems may often be managed in IOT programs or through linkages with health care providers.

Emotional and behavioral conditions or complications. Clients who require a protective environment or a 24-hour structure due to severe emotional or behavioral conditions or other complications should be treated in an inpatient setting. For placement in IOT, clients should be assessed as being in little danger of harming themselves or others. A wide range of emotional and behavioral problems can be safely and effectively managed in IOT programs -- as long as the problems are included in the treatment plan.

Treatment acceptance and resistance. Clients vary with regard to recognition and awareness of the presence and severity of their AOD use disorders and with regard to their acceptance of or resistance to treatment. To be appropriate for IOT, clients must at least agree to participate in treatment, even if they do not have a commitment to recovery. For example, as clinicians utilize motivational enhancement therapies, clients may initially attribute AOD-related problems to others or to external circumstances; ultimately, they may accept personal responsibility for these problems and for recovery.

Relapse potential. Relapse is not a single event but a process that can be interrupted at various points. AOD relapse includes ruminations about AOD use and cravings. It includes high-risk behaviors, including actual AOD use. Patients in IOT may experience AOD craving. However, patients with a persistent and severe lack of impulse control may require a more intense level of care such as inpatient treatment.

Many clients who experience AOD craving with subsequent use may nonetheless be effectively managed in IOT programs. When it occurs, the relapse experience can often be used as an effective therapeutic tool for further relapse prevention training. Relapse can often prompt the active use of learned but as yet unused or unpracticed relapse prevention and coping skills. For example, AOD use may be an opportunity for clients to reexamine their drug hunger triggers and to modify their coping strategies.

Recovery environment. Elements of the recovery environment that may indicate a need for inpatient treatment include a chaotic family with severe conflicts, AOD use within the family or living situation, and physical, sexual, or severe emotional abuse. Other elements that suggest poor matching for the IOT level of care include logistical problems such as lack of transportation or inadequate childcare. However, most AOD treatment clients experience some level of family

or social dysfunction, which can generally be addressed in IOT.

Patients whose work potentially puts the public at risk (such as pilots, bus drivers, and physicians) may experience job restrictions, but are nonetheless potential candidates for IOT.

In order to participate in IOT, the basic food and housing needs of clients should be met. For some clients, meeting these basic needs may involve linkages to social services. Some clients may become engaged in AOD treatment because case management increases the availability of basic services.

Patient Transition From One Level to Another

Like any specific level of AOD treatment, IOT may not fully meet all patients' needs. Rather, IOT is a part of the larger continuum of services. As the treatment needs of patients change, clinicians should make recommendations for their transition from one level of care to another. (See [Exhibit 2-2](#) for a summary of assessment criteria for decisions about level of care.)

To make appropriate treatment recommendations, clinicians must have a thorough understanding of all available treatment resources. Thus, all clinicians and programs that provide AOD treatment and referral services should maintain and regularly update a list of all local and regional AOD and mental health treatment services. This list should also include social service programs, vocational rehabilitation programs, health care resources, churches, self-help programs, and other forms of support such as legal or financial resources. In other words, all AOD programs and clinicians should maintain a thorough and current list of services that can help meet the biopsychosocial and spiritual needs of patients. Ideally, AOD treatment providers will have formal or familiar relationships with community agencies that are most likely to provide needed services.

Clinicians often make referrals to a small group of personally known contacts. Instead, they should carefully identify the specific needs of each client and diligently seek treatment resources that can meet those needs. Clinicians should actively initiate and broaden their contacts with other treatment providers both within and outside of AOD treatment. To create effective and complete networks of health care services, such contacts should include medical, psychiatric, social, and vocational services. Appropriate consents should be secured early in the treatment process to ease communication between separate nonaffiliated treatment providers.

Since the IOT level of care is one component of the larger continuum of care, it is necessary to adequately document treatment services and to provide this documentation to the patient's next care provider. This is necessary to improve the quality of care and to ensure efficient utilization of health care resources.

As described in the following [chapter](#), family and significant others should be part of the treatment process, participating in family sessions and education. With the patient's consent, family members should participate in treatment decisions such as those involving transitions from one level of care to another. Family members and significant others should participate in and be knowledgeable about components of the treatment plan. They can be an important source

of support for the patient during the recovery process.

Treatment Goals

The assessment process identifies specific problems that the clinical team and the client need to address and resolve. Thus, *treatment goals* are the expected therapeutic outcomes that are manifested in observable and measurable changes in behavior. Some of the treatment goals are immediate, some are long term, and others are lifetime goals. Thus, some treatment goals will be met during IOT, while others may be met during later phases of treatment and beyond. Also, treatment goals change over time, as progress is demonstrated.

While there are general treatment goals that are shared by most clients, clients will also have distinctive treatment goals that are based on their individualized needs as determined by a multidimensional, multidisciplinary assessment. Posttreatment goals and interventions should also be addressed in the treatment plan. Discharge planning begins with intake and placement and is a process that culminates in meeting minimal criteria for treatment outcome goals.

AOD treatment goals can be organized according to the six dimensions of illness described in ASAM's patient placement criteria.

Withdrawal Potential

The treatment goal relative to AOD withdrawal is an absence or reduction of the severity of the acute withdrawal syndrome so that intensive medical management is no longer needed. Some patients may have subacute or protracted withdrawal symptoms that are not severe enough to require medical management or to interfere with recovery.

Biomedical Conditions and Complications

For clients in an IOT level of care, biomedical treatment goals include the stabilization of medical problems so that medical monitoring is not required or so that the patient can receive medical management through another service provider. The treatment goal is to resolve biomedical problems enough to allow transition to a lower level of care. For example, severe hypertension can be stabilized with appropriate medication so that intensive monitoring is no longer required.

The following are examples of treatment goals in the area of biomedical problems and complications. These goals may be achieved during IOT. When these goals are unmet during IOT, a treatment plan to achieve them may be initiated during IOT and included as part of the continuing care plan.

- The patient will obtain a personal physician.
- The patient will identify any outstanding medical and dental problems and establish a plan for treatment.
- The patient will develop a personal plan for health maintenance.

- The patient will develop a personal plan for wellness.

Emotional and Behavioral Conditions or Complications

For patients in an IOT level of care, emotional or behavioral treatment goals include the stabilization of problems so that intensive management is not required or so that problems may be adequately managed through another service provider.

Based on specific emotional or behavioral problems identified through a multidisciplinary and multidimensional assessment, the treatment goal is the resolution of problems sufficient to allow a transition to a lower level of care. For example, symptoms of depression may be improved through pharmacotherapeutic intervention so that intensive monitoring is no longer required.

The following are examples of treatment goals in the area of emotional and behavioral problems. These goals may be achieved during IOT, or a treatment plan may be initiated and included as part of the continuing care plan.

- The patient's emotional and behavioral conditions will diminish in severity so that intensive management is no longer necessary.
- The patient is able to appropriately express and process emotions. The patient has learned to recognize, label, and express emotions.
- The patient can identify and discuss feelings of shame and guilt associated with AOD use. The patient can recognize the association between AOD use and personal shame and guilt issues.
- The patient can identify problems that may require ongoing psychotherapeutic support and identify a plan for obtaining such support.
- The patient has learned anger management and impulse control techniques.
- The patient has learned cognitive techniques to diminish symptoms of depression.
- The patient has learned assertiveness skills.

Treatment Acceptance and Resistance

For patients in an IOT level of care, treatment goals that relate to the issues of treatment acceptance and resistance include: 1) awareness and self-recognition of the AOD use disorder and its consequences, 2) recognition of the severity of the AOD use disorder, and 3) a personal acceptance of the AOD problem and the general goals of AOD treatment.

The following are examples of treatment goals in the area of the acceptance of or resistance to treatment. These goals may be achieved during IOT, or a treatment plan may be initiated and included as part of the continuing care plan.

- The patient recognizes his or her inability to control the use of AODs.
- The patient accepts personal responsibility for recovery.
- The patient understands the association between negative consequences and continued use of AODs.
- The patient recognizes that his or her relationship with AODs is self-defeating.

Relapse Potential

Remaining abstinent from all drugs including alcohol is a usual goal for patients in AOD treatment. For patients in an IOT level of care, treatment goals regarding relapse potential include the integration of relapse prevention skills into their behavior in such a way that they can continue their recovery process without intensive treatment or intervention. For example, a patient may routinely call his or her 12-step sponsor and attend the first available meeting after an episode of stress or craving. Generally, these treatment goals include awareness, early identification, and management of progressive relapse signs, as well as early intervention planning for relapse.

The following are examples of treatment goals in the area of relapse potential. These goals may be achieved during IOT, or through a treatment plan initiated and included as part of the continuing care plan.

- The patient understands the relationship between triggers, craving, and relapse.
- The patient has identified personal triggers for AOD craving and use.
- The patient has developed, integrated, and internalized skills and strategies for coping with triggers and high-risk situations.
- The patient has stopped participating in high-risk behaviors and activities and has discontinued high-risk relationships.
- The patient has developed AOD-refusal skills.

Recovery Environment

For patients in an IOT level of care, the treatment goals that relate to recovery environment include either improvements in the patient's environment that are sufficient to support an ongoing recovery process or acquisition of skills that are sufficient to cope successfully with a problem environment.

The following are examples of treatment goals in the area of the recovery environment. These goals may be achieved during IOT or initiated and included as part of the continuing care plan.

- The patient will develop living habits that promote abstinence and recovery.
- The patient will develop community supports that specifically promote abstinent behavior and a healthy lifestyle.
- The patient will develop the skills necessary to establish and maintain close interpersonal relationships.
- The patient will learn strategies and skills that enhance personal socialization.
- The patient will develop a plan for educational or vocational improvement as necessary.
- The patient will develop a spiritual or moral environment.
- The patient will plan for structured participation in a 12-step recovery program or a reasonable alternative.
- The patient will develop a plan for sustaining family recovery and achieving positive family relationships.
- The patient will identify community resources that may provide assistance for recovery.

A Final Thought

In many ways, this TIP chapter describes ideal patient placement decisions. In practice, however, clinical issues may not be as neatly presented and organized. Also, limited resources may restrict or interfere with the opportunity to adhere to these or other guidelines. Thus, the reader is advised to apply these or other guidelines to his or her own treatment setting and to use them in ways that are most applicable.

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Chapter 3 -- Components of an Effective IOT Program

Recent developments in the field of alcohol and other drug (AOD) abuse treatment, along with a prevalent interest in and awareness of the effectiveness of the intensive outpatient treatment (IOT) level of care, have promoted the growth of IOT programs. This chapter primarily addresses services that are considered essential to any IOT program, as well as services that can be described as optimal. The chapter includes a review of the salient clinical issues and characteristics of IOT. A framework for considering IOT programs, rather than an exhaustive clinical explication, is presented. Although the needs of special groups (such as clients with dual disorders, pregnant women, elderly people, and gay men and lesbians) are not specifically addressed in this section ([see Chapter 5](#)), the services described here can be adapted for programs that specialize in meeting the needs of these and other groups.

Rationale

Traditional outpatient treatment generally consists of individual or group counseling. This approach is not sufficiently intensive to meet the needs of patients with moderate to severe AOD disorders, since clients engage in therapy sessions only once or twice a week. Traditional outpatient treatment usually offers fewer types of treatment services than IOT and is generally not organized to address the multidimensional needs of AOD-dependent patients.

At the other end of the spectrum of treatment intensity is inpatient treatment: medically managed intensive inpatient treatment and medically monitored intensive inpatient treatment. These two levels of care involve an organized service of around-the-clock evaluation, care, and treatment in an inpatient setting. In this setting, patients who have severe withdrawal, and/or medical, emotional, or behavioral problems can receive primary medical and nursing services.

IOT represents an approach to addiction treatment at a level of intensity that is intermediate between intensive inpatient treatment and traditional outpatient treatment. [Chapter 2](#) includes a discussion of the levels of care. When clients are appropriately placed, IOT provides a level of effectiveness at significantly less expense that is equivalent to the effectiveness of inpatient programs. IOT has significant advantages as a level of care organized to treat clients with moderate to severe AOD disorders. These advantages can be recognized in terms of cost, attractiveness to patients, and clinical efficacy.

Advantages

Financial and Cost Benefits

AOD abuse has been shown to have a tremendous economic impact on society. The Institute of Medicine estimates that the annual total cost to society of alcohol problems is \$117 billion. However, less than \$10 billion is spent annually on total treatment costs for alcohol problems (Institute of Medicine, 1990), a negligible amount when compared with the costs to society. However, in an era of health care reform, the AOD treatment field has the same commitment as other health care fields to cost-efficient quality care. Within the context of a continuum of care, IOT is an example of innovative change contributing to the attainment of the national objective of reducing the costs of health care.

The bulk of AOD abuse costs relate to morbidity, mortality, and crime. Additional costs are for support services and treatment for fetal alcohol syndrome, acquired immunodeficiency syndrome (AIDS), and other medical comorbidity, as well as services to persons living with someone who has an AOD disorder.

One of the only clear and consistent indicators of positive AOD treatment outcome is the length of time an individual is involved with AOD treatment services. Treatment in an intensive outpatient setting can be provided for many more weeks than in an inpatient setting, and at significantly less cost. Further, studies in which traditional 28-day inpatient treatment programs for AOD abuse have been compared with IOT have demonstrated comparable clinical outcomes ([Fink et al., 1985](#)).

Cost savings are also realized in IOT programs in terms of continued productivity of clients who remain able to work and those who have fewer days lost from school or employment. In addition, clients are able to continue functioning in such important roles as parents and homemakers.

Additional and substantial cost savings can occur when an integrated treatment plan is used to link various service providers, including primary health care providers. Early intervention and preventive services can lead to the type of savings associated with preventive medicine. AOD intervention offered in coordination with health care networking may ensure less complicated medical treatment and reduced comorbidity. IOT programs can easily be organized as a component of care within a health care system.

Consumer Benefits

In contrast to traditional inpatient treatment, IOT allows services to be provided at times that are convenient to clients. The flexible program design of IOT also allows the provider to tailor services in response to regional variations and the needs of special groups, both in terms of core elements of the program and the special services that may be added to existing programs. The special accommodations that can be provided to patients make IOT an attractive option, especially in situations requiring flexibility.

Clients may view confidentiality as less of an issue in IOT settings, because unlike in inpatient settings, clients are not separated from their daily milieu -- thus avoiding protracted absences from work or family. Furthermore, an IOT approach avoids the disincentive to seek treatment that is often experienced by patients when the only AOD treatment choice is hospitalization. Flexibility, reduced barriers to seeking treatment, and enhanced confidentiality all serve to increase self-referral and utilization of this level of care.

Clinical Benefits

Increased duration of treatment. Among the many advantages of IOT is the increased duration of treatment. This allows for a prolonged opportunity to engage and treat clients while they remain in their home community. IOT provides for an increased opportunity for patients to practice newly learned behaviors. Clients in IOT are given sufficient time to incorporate new identities as recovering people with extended support, such as enhanced opportunities to become part of a fellowship of recovering people. IOT sets the stage for continuing outpatient care, which further increases the likelihood of successful recovery; the longer patients remain in treatment, the better the prognosis for full recovery.

Flexible levels of care. The severity of addiction and the intensity of symptoms vary among patients and vary over time for each patient. Generally, people require more intense treatment initially, followed by progressively less intense care. However, problems such as relapse, medical and social crises, and the emergence of psychiatric or subacute withdrawal symptoms demand a temporary increase in treatment intensity and/or level of care. IOT provides significant clinical flexibility that can be used to respond to clients' individual treatment needs -- especially when these needs change over time. Thus, as a client's treatment needs become more or less intense, the IOT program can likewise increase or decrease the intensity of treatment for that individual.

Increased patient caseload levels and improved patient retention. When staffed appropriately, IOT programs can usually treat a high volume of patients. A larger patient population makes it easier to create groups devoted to special issues such as incest, sexuality, anger management, and relapse. The IOT structure, which relies on a team approach and a therapeutic milieu, may result in a higher retention rate than low-intensity outpatient treatment. This means that staff can spend more time on effective caseload management. The flexible nature of the IOT setting also permits the ability to modify the structure and character of special issues groups.

Daily application of learning. IOT promotes the daily application of what is learned in treatment. Clients can put into immediate practice the coping strategies needed to adapt to living without AODs. They learn to confront daily challenges -- indeed, they must do so. New behaviors are learned within the context of the client's normal existence and environment, rather than according to prescribed strategies that are learned within a sheltered environment and only later, after discharge, put into practice. Changes can be made and supported incrementally and on a daily basis, thus providing an increased likelihood for permanency. Rather than having a hiatus from life in the "real world," the client in an IOT system must face the daily challenges posed by recovery. Changes thus become internalized, applied components of the client's life.

Community-centered support. Because IOT programs promote treatment that is patient-driven and centered on the whole person, they can assertively address problems related to family and work and to social, psychological, and emotional well-being. Psychosocial supports from family, employer, and community can be readily established or reestablished with an outpatient treatment experience. Clients are in a good position to confront challenges because not only have they learned new behavioral and cognitive responses to cravings, and have had real-life opportunities to practice relapse prevention techniques, but they also have an established community-based support network, including family and employer involvement with the IOT program.

Relapse management support. Because of the daily contact with patients afforded by IOT as opposed to traditional outpatient treatment, relapses can be addressed during early stages, often before actual AOD use. The approach of most IOT programs is to view relapses less as failures and more as evidence that changes are needed in the patient's treatment goals, lifestyle, and/or social systems. In IOT, clients can usually identify relapse triggers and issues with ease since they have real-world experiences to draw upon. When relapses do occur and when they are framed as potentially positive learning experiences rather than as stigmatizing episodes, the likelihood of patients remaining in treatment is heightened. Clinical assessment of the severity and duration of the relapse is essential.

Patient responsibility. Since clients are responsible for their participation, passive participation is difficult in IOT programs. IOT tends to empower clients, who must develop incentives to keep returning to treatment. In IOT, clients are less able to be reluctant or resistant observers. Personal responsibility is thus placed squarely on clients' shoulders.

Enhanced self-help participation. Self-help resources such as Alcoholics Anonymous and Narcotics Anonymous (AA and NA) are often essential to patient recovery during and beyond the IOT level of care. A special advantage of IOT is that clients can establish relationships to the community self-help support programs that they will likely rely on for extended support. Rather than identifying local groups after the completion of inpatient treatment, patients can be settled into an appropriate community-based resource prior to their completion of intensive treatment.

Enhanced therapeutic milieu. IOT programs offer patients the opportunity to develop relationships with other clients that can be readily fostered and maintained throughout and beyond the treatment experience. Clients can relate to one another outside of the parameters of the program. Since they likely live close to one another, they can continue mutual support once IOT is completed.

Problems and Challenges

IOT is a level of care that exists within the broader continuum of care. As such, IOT has limitations, disadvantages, and potential problems. Chief among these challenges are problems associated with the retention of patients, reimbursement and related financial concerns, and the management of acute crises.

It is possible for an element of IOT that generally provides significant strength to occasionally become a disadvantage. For example, participation in treatment while living in one's normal environment provides daily opportunities to practice relapse prevention and drug refusal skills. However, this arrangement also provides daily opportunities to encounter numerous social, environmental, and emotional triggers for drug craving and relapse. Like all other medical and psychological interventions, IOT involves both benefits and risks. Thus, patient placement in IOT must be considered in terms of costs and benefits.

Advantages of IOT Programs Over Inpatient and Typical Outpatient Programs

- Reduced financial costs over inpatient treatment
 - Flexible, accessible services
 - Enhanced confidentiality over inpatient treatment (clients maintain usual routines)
 - Increased duration of treatment (better prognosis)
 - Clinical flexibility to respond to individual needs
 - Higher retention rate than low-intensity outpatient care
 - Daily real-world opportunities for clients to apply learned skills
 - Increased opportunities to establish community-based supports
 - Enhanced treatment for relapse
 - Greater patient responsibility
 - Participation in local self-help groups from the outset of intensive treatment
 - Enhanced ability to develop long-term supportive relations with other clients.
-

Retention Problems

One of the challenges of IOT relates to client retention and completion of treatment. The potential for encounters with drug craving cues and triggers, the potential for exposure and access to AODs, the lack of insulation from family and social crises, and the absence of supervision during nontreatment hours may contribute to retention problems.

While physical health is often the last aspect of health to deteriorate because of AOD addiction, it is often the first aspect to return to normal. Many patients equate restoration of physical health with being "cured." Thus, as some patients begin feeling better physically, they may feel that no further treatment is necessary.

Thus, clients in an IOT program should be exposed to assertive education and training about triggers, drug refusal techniques, handling social and emotional crises, feeling "cured," and after-hour peer-support and self-help programs.

Reimbursement Issues

The financial challenges inherent in IOT stem from the fact that it remains a relatively new approach. Problems in this area are related to definition, reimbursement, standardization,

resistance within the AOD field, and competition with inpatient programs. The introduction of IOT comes at a time when payers are skeptical of providers and when there is an increased demand for reduction of health care costs. Overall, there is less experience with program and fiscal management of IOT programs, and third-party reimbursement for IOT services can be difficult to secure. The use of nonuniform admission and placement criteria further complicates the reimbursement issue. Additional difficulties may be posed by the relatively low profit margin experienced by many IOT programs, and the constant demand for a stable and high census. In some cases, a minimum number of days are required for reimbursement. Reimbursement may be lost for the whole week if a patient misses a certain number of days.

It is difficult for IOT programs to operate at a cost-effective level of utilization if too few clients are enrolled. In addition, the high flexibility of IOT programs makes it difficult to project revenue. [Chapter 6](#) describes problems that relate to reimbursement and managed care.

Crisis Management

While in treatment, patients often lack coping skills to adequately deal with psychological, social, and medical crises. Given the complexity of AOD patients and the emphasis on reduced costs of care, patients in IOT are often at risk for complications. The IOT level of care provides less control over acute patient management problems. An important example is the fact that clients typically experience acute crises during after-hour periods. For this reason, it is recommended that IOT programs provide 24-hour crisis intervention services.

Problems and Challenges Within IOT Programs

- Risk of relapse heightened by uncontrolled environmental factors
- Less insulation from family and social crises
- Absence of supervision during nontreatment hours
- Increased difficulty of obtaining third-party reimbursement
- Less control over acute patient management problems.

Treatment Components

IOT programs for AOD abuse will differ with regard to the number, type, and intensity of treatment services provided. Indeed, treatment services can be categorized into core, optimal, and enhancing elements.

- **Core elements.** All IOT programs should have certain core or minimal treatment services. These include screening, assessment, treatment planning, 24-hour crisis management, pharmacotherapy, individual and group therapy, client and family education, case management, toxicology screening, and program outcome evaluation.

- **Optimal elements.** IOT programs that provide more than the basic or minimal treatment services exist on a continuum that ranges from "complete" to "enhanced." These optimal elements include family therapy, childcare and transportation, recreation and leisure, continuing care, alumni activities, and outreach efforts in the community.
- **Enhancing elements.** Programs may provide treatment services that can be described as adjunctive therapies. These optional elements include psychodrama, stress reduction techniques, acupuncture, biofeedback, art therapy, and other therapeutic services.

Core Elements

There are several minimal elements that are essential to the effective operation of a basic IOT program. While inclusion of all of these elements will not guarantee effectiveness, the implementation of these components ensures that certain barriers to effective care are removed. Describing them as core elements is based primarily on clinical experience. Vigorous research and examination are required to determine which of these elements indeed makes a difference in the experience and outcomes of clients treated in IOT. Although individual program configurations and target client differences can restrict and influence the way in which some treatment services are organized and provided, the following treatment services should be considered critical for IOT programs.

Program Leadership

The management and administration of an IOT program should provide leadership through the development and expression of a program mission, philosophy, and development plan. Further, program management and administration should ensure that the program has the financial and philosophical support to successfully meet its mission, goals, and objectives.

An IOT program requires planning, coordination, and evaluation of service delivery, including the maintenance of essential linkages with payers and referral sources. Good program management fosters continuous quality improvement and is required for financial planning and management. New opportunities for program expansion and improvement must be continually identified, as should changes in regional and national trends in AOD abuse and treatment.

Program administration should be organized in such a way that the program can proactively deal with the changes and challenges of the times. A key responsibility of program management is to provide a working environment that enhances staff productivity. Human resources support should be organized to meet the needs of the work force in order to ensure a successful and healthy operation (see [Chapter 4](#) for discussion of staffing issues).

Screening

Screening for AOD abuse and dependence is a treatment service that identifies whether an individual is appropriate for an AOD abuse assessment. An initial, brief screening of a potential patient may be done during the first phone contact or through a scheduled or unscheduled walk-in. During this initial screening, basic data are gathered and the individual is encouraged to participate in an assessment if appropriate.

Some people can be screened out as inappropriate for IOT without their ever coming in to the program. In these instances, clients should be referred to appropriate resources. To the extent possible, medical emergencies should be screened and the client should be given a brief overview of the services provided by the program. The purpose of this initial screening is to determine whether the individual is likely to be an appropriate candidate for the program according to clear, previously determined admission criteria that include guidelines on clinical and financial eligibility.

There are several purposes and reasons for providing AOD abuse screening. They include:

- Determining the need for an AOD assessment
- Ensuring immediate placement in the appropriate level of care
- Responding to communications from referral sources, self-referrals, families, and others about the potential for AOD treatment
- Engaging and involving the referral source with the treatment program and the treatment process
- Documenting information gained during crisis interventions and assisting clients to reach other levels of care such as emergency room treatment
- Scheduling appointments for assessment and preparing patients for the assessment process.

It is recommended that clinical staff be involved in front-line AOD screening. Nonclinical staff are appropriate for answering questions about the program or for the registration of clients, but they should not be placed in a situation that involves clinical judgment.

When initial contact is made with a potential client, staff members handling the contact should realize that, although the call or visit may be routine for them, this initial step has enormous implications for the client. He or she may experience feelings of fear, anxiety, rage, apprehension, resentment, or ambivalence. Staff should be sensitive to the highly charged emotional set that is typical of many clients when they first contact a treatment site. It is important to congratulate people who contact an AOD program (whether for themselves or for others) for taking such an important step.

Assessment and Intake

Once a potential client has been screened, an assessment should be arranged as soon as possible if the person seems to be an appropriate candidate for the level of care provided by the treatment program. The goal of the assessment process should be to determine the individual needs of each patient through the completion of a diagnostic evaluation and to confirm the appropriateness of participation according to the program's admission criteria. The initial assessment should provide a complete psychosocial profile of each person, including all problem areas such as AOD use; psychological, physical, legal, and vocational problems and issues; and family and other social relationships.

An alliance should be successfully reached with the client prior to completing the assessment interview. Also, clients should be informed about confidentiality regulations and other informed consent issues. Both of these will help to promote a trusting relationship between the client and the program staff.

There should be a mechanism for immediate, same-day involvement in the program so that clients can be placed in treatment at the earliest opportunity. Encouragement and positive reinforcement for clients' participation are required throughout this process. Those for whom medical stability is in question should be examined by a physician prior to admission. It is advised that patients receive a physical examination within the first days of treatment when possible. This will ensure that medical issues are appropriately addressed in the treatment plan. If the assessment reveals that a client is inappropriate for participation in the IOT program, the program is responsible for linking the client with an appropriate level of care.

Procedures for registering clients should be developed to ensure their appropriate transition from the assessment to the assigned level of care. It is useful to collect financial information prior to the assignment, to ensure availability of services and appropriate placement.

Intake and registration procedures should include patient education regarding program policies and procedures, rules and regulations, expectations and rights, program schedules, the consequences of noncompliance, the use of AODs during treatment, the role of toxicology screening results, and the extent and limits of confidentiality.

Assessment within AOD treatment is a comprehensive, multidimensional process. Readers are referred to related TIPs for further clarification of the assessment of AOD abuse disorders. These TIPs are *Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents*; *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*; and *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*.

Toxicology Screening

Routine and random drug testing of body fluids for AOD use is essential to any IOT program. Screening should be performed randomly and perhaps as often as once a week, especially at the beginning of treatment. In some cases, asking clients to submit to screening more than weekly may prove beneficial.

Toxicology screening benefits patients by providing additional structure in terms of relapse prevention and fosters honesty about relapses by reducing patients' ability to manipulate the IOT staff, their employers, and other people in their lives. Screenings can help to reduce clients' ability to minimize or deny AOD use. All clients must be taught that the purpose of toxicology testing is to enhance accountability, to help maintain a drug-free environment, and to help achieve treatment goals. Screening also serves as a measure of client progress with respect to abstinence. Toxicology screening has other functions that relate to counseling issues -- such as confronting clients who claim to be abstinent with urine tests that are positive for AOD use.

Patients must provide written informed consent regarding who, outside of the program staff, may have access to or be informed of toxicology screen results. The measures taken to address positive screening results should not be punitive, but at the same time, patients should understand that some consequences may be outside the control of the program or the therapist.

If the results of toxicology screening are to be used for other than strictly internal purposes, the method used must meet requirements for certification by the National Institute of Drug Abuse and the Clinical Laboratory Improvement Act. When providing urine samples for analysis, clients should always be supervised ("observed urines") to reduce the opportunities for falsification. This is particularly critical when urine samples are used for legal or employment purposes. Appropriate procedures should be developed regarding the safe collection, handling, storage, and testing of urine samples.

Treatment Planning

There is nothing unique about treatment planning in an IOT program. Rather, treatment planning should follow the standard of care for AOD treatment in general. Based on the findings of the assessment, goals are established for an individualized master treatment plan that describes specific goals and actions to be taken. The treatment plan is a comprehensive and evolving record of treatment goals reflecting the client's cognitive, emotional, social, physical, and behavioral changes.

The treatment plan should be based on the patient's expressed objectives and on findings from the initial assessment, medical examination, toxicology screenings, and the biopsychosocial assessment. Specific, measurable goals that the patient agrees to accomplish during the course of treatment should be identified in the master treatment plan. The treatment plan should be developed by the treatment team and the patient together; it should be updated and reviewed regularly to ensure that it reflects the patient's progress toward established treatment goals and to identify new problems that require treatment. The treatment plan should serve as a "road map" for the treatment providers and the client, so that everyone understands "where the client intends to go and how the client will get there."

A treatment contract can be a part of the master treatment plan. It is a useful tool to address problems that arise throughout the course of treatment. A treatment contract consists of specific behavioral commitments to which the patient agrees. It can provide structure and support to the patient.

24-Hour Crisis Management Services

Because clients' problems do not typically conform to the working hours of the IOT service, arrangements must be made for clients to have access to emergency services and counseling support on a 24-hour basis. In smaller programs, this may be accomplished by agreements with existing services such as hotlines, crisis intervention services, and hospital emergency rooms. Larger programs that offer comprehensive addiction services may provide crisis intervention services through on-call specialists connected to an answering service and/or a paging system, or through the utilization of staff members who work in residential programs.

Pharmacotherapy Services

Pharmacotherapy services include the medical management of withdrawal, pharmacologic interventions such as methadone and naltrexone, treatment of psychiatric disorders, and

treatment of medical problems including HIV and AIDS. Pharmacotherapy should not be a stand-alone service, but should be integrated with other treatment services.

Pharmacotherapy should be available for patients who require support through ambulatory detoxification, anti-craving and anti-addiction medications, and psychotropic medications to manage psychiatric disorders, as well as for HIV-positive clients who require antiretroviral therapy and other medications. Although some programs may elect not to use anti-craving and anti-addiction medications, it is essential that patients with major mental illness be maintained on appropriate psychotropic medications.

Ideally, the outpatient use of prescribed psychoactive substances will be carefully monitored on site, or possibly by other arrangements such as regular visits to the patient's physician or a mental health clinic. The coordination of such services is critical, and prescribing physicians should be integral or extended members of the treatment team.

For in-depth discussions of issues related to pharmacotherapy in addiction treatment, the reader is encouraged to read the TIP on *State Methadone Treatment Guidelines*. Also, the TIPs *Meeting Patient Needs in Opioid Substitution Therapy: Matching Patients to Treatment Services and Detoxification from Alcohol and Other Drugs* are scheduled for publication in 1994.

Individual Counseling

In the past, counseling has often been distinguished from therapy in that individual psychotherapy generally refers to a therapeutic attempt to help clients identify self-defeating patterns of behavior and unconscious motivations for specific behaviors. Psychotherapy often was organized toward the resolution of long-standing conscious and unconscious conflicts. Counseling in an AOD setting generally describes a therapeutic attempt to help patients solve specific acute problems that are barriers to complying with or benefitting from AOD treatment. Although extended examination of developmental and unconscious issues are not discouraged, brief interventions are seen as preferable to long-term individual work because of cost considerations. Particularly during the early stages of treatment, individual and group counseling sessions are valuable tools. Individual counseling can help:

- Maintain clients' participation in the treatment process by continual review and clarification of treatment goals and objectives
- Reassure clients about fears and anxieties that are an expected part of the behavioral change process
- Enhance retention of clients in the program by strengthening the client-counselor relationship
- Identify new and healthy responses and solutions to stressful and difficult situations.

Individual counseling provides the basis for a clinical relationship that will be sustained throughout the course of treatment. Multiple sessions of individual counseling, even if brief, are important in developing a solid therapeutic relationship between the patient and the counselor.

Individual sessions can be used to address routine issues that do not benefit either the client or group members by discussion in a group setting. Conversely, in individual sessions, clients often

disclose certain issues -- particularly those around which guilt or shame is experienced -- that could be beneficially addressed in a group setting. Clients should be gently and sensitively encouraged to present such issues in a group setting, thereby defusing the emotional power of the issues and helping clients gain reassurance from peers.

Group Therapy

Group therapy is a standard component of addiction treatment and should be provided by a qualified clinician utilizing group processes and dynamics to facilitate the treatment process. Certain patients may not be immediately prepared to tolerate or work effectively within a group. Appropriateness for group therapy should be considered by the treatment team before patients are admitted to group therapy situations. Before participating in group therapy, clients should be oriented regarding appropriate behavior in the group, and other group rules should be explained, such as those associated with attendance, participation, honesty, feedback to others, and confidentiality.

People who are addicted to AODs tend to isolate themselves and grow alienated from others. Group therapy serves to break down isolating tendencies and gives clients a reference point from which to explore the fears and anxieties they experience as they contemplate a drug-free lifestyle. The dynamic of peer confrontation and support can be fully experienced only in a group setting.

Often the more experienced members of a group can anticipate and identify the pitfalls and experiences that may be expected during the recovery process for less experienced clients. Also, group norms help establish healthy recovery patterns ([Yalom, 1985](#)). Further, the quality and strength of the therapeutic milieu usually reflect the work clients do in group therapy.

Some group sessions should focus on here-and-now issues such as the desire to use AODs, recent relapses, struggles with potent emotions, or conflicts with other group members or family members. Other examples of special group topics commonly addressed in IOT programs include incest and abuse, gender or cultural issues, family relationships, and sexual orientation. Group sessions that are more cognitively oriented or psychoeducational are different from group therapy. Such education groups are another important component of IOT.

Ideally, therapy groups do not include more than 12 patients and are facilitated by two therapists. Although not always feasible, IOT programs should consider the advantages of dual-therapist groups, including role modeling, coverage during the therapist's absence, and strategic facilitation.

Education Services

The didactic presentation of information on addiction and recovery is considered an educational service. These educational programs, like those offered in individual or group settings, are designed to address core issues of human behavior and development associated with addiction and recovery. Some of the topics covered in educational sessions include:

- The dynamics of addiction and the addiction process
- The role and process of treatment and recovery
- Medical aspects of addiction
- The importance of abstinence from alcohol and all other drugs
- Appropriate use of prescribed and over-the-counter drugs
- Powerlessness and unmanageability of AOD use
- Maximizing the use of self-help and support groups
- Spirituality and the development of an externalized source of support
- The roles of nutrition, exercise, leisure, and recreation in recovery
- Experiencing emotions and feelings without AODs
- Relationship skills
- Sex and sexuality and recovery
- Conflict resolution and confrontation skills
- Family dynamics of addiction
- Healthy relationships and family functioning
- Relapse management skills
- AOD refusal skills
- Avoiding and defusing triggers for craving and relapse
- Minimizing risks for HIV, AIDS, and sexually transmitted diseases.

Generally, this information is effectively delivered through small-group, highly interactive intimate discussions rather than in impersonal large-group lectures. Adjunctive activities may include handouts or writing assignments. Numerous videos and publications have been developed to support educational efforts. It is important that patient responses to these sessions be discussed. All educational programs should provide structure and time for productive interactive discussion and processing of the information being learned.

Providers of educational services should have mastery of their subjects and should avoid discussing subjects in which they are not well versed. Since patients rely on the accuracy and relevance of these sessions, the quality of these services is important. Consideration should be given to brevity. Generally, the normal attention span is 20 minutes, and presentations should be organized accordingly.

Family Education and Counseling

Family member participation is increasingly viewed as a critical area of AOD treatment. Didactic and experiential sessions should be provided for family members and significant others of patients enrolled in AOD treatment programs. These sessions help engage clients' families in treatment and enhance family members' understanding of the treatment and recovery process. Topics that might be covered in a family educational session include:

- The dynamics of addiction, treatment, and recovery in the family
- Relapse and relapse prevention
- Family issues common in addicted families
- Enabling and denial
- Healthy family functioning
- Healthy detachment and "tough love"

- Communication and problem solving in the family
- Management of family social functions
- Introduction to Al-Anon, Alateen, and other relevant support systems for family members.

One of the purposes of family counseling is to educate family members about family dynamics and issues associated with addiction and recovery. Family counseling should provide the structure to support stabilization in the family and to assist the entire family in making changes that support the recovery of the client and all members of the family.

Family education and counseling provide an opportunity for family members to identify and address personal family dynamics and issues associated with the identified patient's AOD use and to develop solution-oriented strategies for change to support AOD recovery.

Self-Help and Support Group Orientation

Patients benefit from involvement with the 12-step programs and other self-help resources both during and after intensive AOD treatment. Studies have shown that those who participate in 12-step self-help groups such as Alcoholics Anonymous have higher rates of abstinence than those who do not ([Hoffman and Harrison, 1988](#)). The rates of abstinence are higher still among people who participate in aftercare plus Alcoholics Anonymous ([Hoffman and Harrison, 1988](#); [1988a](#); [Hoffman and Miller, 1992](#)).

In many ways, self-help participation is the bridge between acute treatment and long-term recovery. IOT programs provide a limited number of treatment hours per week, and treatment continues for a limited time thereafter. Participation in self-help and other support group activities is vital to ensuring extended support beyond the treatment episode. The 12-step programs -- Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous -- are widely known as the self-help resources that best support sobriety and recovery.

Patients should be informed that there is variability among 12-step group meetings. For instance, some AA meetings are open to everyone, while some are open only to people who have the desire to stop drinking. Some meetings are open to a specific group of people. There are 12-step meetings attended only by men, women, gay men, lesbians, the hearing impaired, Spanish-speaking people, elderly people, people with AIDS, or nonsmokers. In many areas, there are 12-step meetings for impaired medical professionals and "double trouble" groups for clients with dual disorders.

Some 12-step meetings are regular (discussion) meetings, while others focus on the 12 steps ("step meetings"), and some feature people talking about their experiences with AODs and recovery ("speaker meetings"). Clients should understand the variety of options available in their community and know how to gain access to them and what to expect during the meetings. Clients should learn about the traditions and services associated with these programs, such as concepts of sponsorship and service to others. Clients should be encouraged not only to attend but to actively participate in the meetings. All clients should be provided with a meeting directory of 12-step groups.

Staff members should receive training about the predictable resistances that patients often have when introduced to self-help participation, especially resistance regarding the spiritual focus of many of the 12-step programs. IOT staff members should be sensitive to the need for matching individual patients to a "home group" of people with similar backgrounds, culture, and experience. A special advantage of IOT is that patients can identify and participate in their home group before leaving treatment.

Although the 12-step programs are the most numerous and accessible self-help resources available, they are not the only source of self-help support. While some people will reject the 12-step programs as part of an overall rejection of AOD treatment, some people will reject the 12-step programs in favor of alternative self-help resources. AOD treatment staff should be willing to help such clients explore reasonable alternatives that will genuinely help them establish and maintain sobriety and promote emotional and spiritual growth. The effectiveness of the self-help experience should be based on the client's comfort level and assumed benefit rather than on the experience or traditional outlook of the treatment provider.

AOD treatment staff should be familiar with alternatives to 12-step programs that may be available in their area, such as Rational Recovery Systems, Secular Organizations for Sobriety (Save Ourselves), and Women for Sobriety. There are also self-help groups that have a specific religious orientation such as Overcomers Outreach (for Christians) and the self-help group named Jewish Alcoholics, Chemically Dependent Persons and Significant Others.

Case Management Services

IOT programs should have arrangements or agreements with other organizations for delivery of support services not provided by the treatment program (such as vocational rehabilitation, social services, and employment services). The case manager links the client with these other services, manages the client's treatment plan, and ensures the client's appropriate legal consent. Programs treating individuals with children should also provide or have reliable linkages to child care services.

For clients to benefit fully from IOT, issues identified in the biopsychosocial assessment need to be addressed. Linkages should be provided to services called for in the master treatment plan, such as primary health care, job skills, child care, vocational and educational training, and transportation to and from the treatment site. Case management functions include securing the linkage and followup to ensure the provision of these services or of alternative services and monitoring this process until the identified need has been addressed. The absence of these critical services can create barriers to effective treatment. For example, not having child care makes it impossible for some parents to participate in treatment and family services. As the treatment field advances in its effort to provide whole-person care, and as clients continue to present with significant complications and special needs, case management services will be increasingly important in the treatment of AOD disorders.

Discharge and Transitional Service Planning

To ensure that the recovery process continues beyond the point of intensive treatment, a continuing care plan should be developed by the patient and the therapist. The objectives and goals identified during the initial phases of treatment are carried forth in this written plan, which specifies the activities and objectives that will enable the client to sustain abstinence and a recovery-oriented lifestyle. Issues left unresolved should be addressed in the continuing care treatment plan.

Transition planning consists of preparing the client for completion of intensive treatment and developing plans for the client's ongoing support for recovery. These plans should be established early in the treatment process and may include outpatient services, group counseling, vocational training, ongoing individual or family therapy, and/or self-help group participation.

Program and Outcome Evaluation

Evaluative studies are critical in determining an IOT program's effectiveness as measured by factors such as completion rate, abstinence, quality of life, employment and workplace stability, and reduction or cessation of criminal behaviors. Outcome evaluations assist the program to identify its rates of positive versus negative outcomes and to develop new and innovative services. Outcome evaluations should not be used as a punitive tool, nor to determine salary or pay scales. Rather, they can be used to point out performance issues that require ongoing staff training and to identify those intervention services that best help the addicted patient.

It is clear that the treatment of clients for AOD abuse is a difficult business. Programs should be careful in developing standards of care to identify fair and reasonable outcome indicators. Lifelong abstinence of graduates, for example, would not only be too ambitious to study but would also prove to be an unreasonable expectation. At the very least, it is recommended that IOT programs track patient retention and completion rates and related variables.

Optimal Elements

The planning, development, staffing, and allocation of resources for IOT programs should be approached with the specific goal of meeting the treatment needs of the target population. Therefore, it must be decided what treatment needs patients are likely to have before decisions are made about the types of treatment services that will be offered. All IOT programs should have the core elements described in the previous section. Depending on the mission and scope of specific IOT programs, many will require the elements described below as optimal elements.

Core or Minimal Elements of the IOT Level of Care

- High quality leadership and administrative support
- AOD screening
- AOD assessment

- Intake and registration procedures
 - Routine and random toxicology screening
 - Treatment planning
 - 24-hour crisis management
 - Pharmacotherapy and medication management
 - Individual counseling
 - Group therapy
 - Education about AOD issues
 - Family education and counseling
 - Self-help and support group orientation
 - Case management services
 - Discharge and transitional service planning
 - Program and outcome evaluation.
-

In other words, while certain AOD treatment services can be considered core elements that constitute the minimal elements for an IOT program, and other treatment services can be considered optimal elements that help to define an enhanced IOT program, certain so-called optimal elements can be considered core elements when they are required to meet the needs of the target population. For example, an IOT program that primarily treats single gay men without children who live in a specific neighborhood may not need child care or transportation services. In contrast, a program that primarily treats working mothers who are dispersed throughout a larger area may define child care and transportation services as core elements. Although it may not be realistic or necessary for all IOT programs to offer the complete array of core and optimal elements that are recommended in this TIP, all programs are encouraged to consider these services.

Outpatient Withdrawal Management

The medically supervised management of AOD withdrawal on an outpatient basis can be a valuable service of an enhanced IOT program. There is increasing evidence that withdrawal from AODs can be safely and cost-efficiently managed on an outpatient basis. To support this function, IOT programs are advised to secure or coordinate with appropriate medical resources to ensure that patients are served in the least restrictive level of care. Daily or near-daily withdrawal monitoring must be supported by an array of services, including individual and group counseling as well as nursing and physician services. This should not be a freestanding function, but must be linked with appropriate support services.

Family, Marital, or Couples Therapy

Therapy with a client's family, spouse, or significant other may be provided to address treatment and recovery issues as they relate to family dysfunction or problems in relationships with these individuals. In some cases, additional individual assessment and therapy with qualified professionals may also be appropriate during intensive outpatient treatment to explore issues that surface during treatment.

This type of assessment and subsequent treatment must be conducted by professionals with appropriate levels of experience, training, and supervision in family systems therapy. Such professionals should be well-grounded in treating family dynamics that are distorted due to AOD use in the family. Clients may require intensive family therapy to address long-term family dysfunction or issues related to family of origin. For this aspect of treatment, the family, in essence, becomes the patient.

Several treatment strategies can be helpful in addressing family issues, including: family counseling with a primary therapist, family education groups, and multifamily therapy groups.

Multifamily group therapy is a valuable treatment service for IOT programs. Bringing families together to share common experiences and issues can provide a tremendous opportunity for support and problem solving. Families that participate in multifamily therapy may feel less isolated and alone in their struggles. An extended milieu that includes family members can be established, often leading to supportive relationships beyond the duration of the program.

Special services to children of AOD-abusing clients may have particular benefit and should be considered if possible. It has long been known that the children of AOD abusers are at risk for AOD abuse, depression, attention-deficit disorder, and behavioral disorders.

Problems such as learning disabilities, sexual dysfunctions, or neurological impairments may impede or truncate the treatment process if not addressed.

Parenting Skills Training

One of the goals of AOD treatment for women with children is to help women keep their families intact -- unless they are abusing or neglecting their children. Indeed, compared with inpatient treatment, IOT may be particularly effective for stabilizing family relationships, since it allows patients to continue to function in their family roles during the treatment process ([Longabaugh et al., 1983](#)). (When IOT staff become aware that child abuse or neglect is occurring, child abuse and protection laws must be followed.)

Child Care and Transportation Services

In an optimal setting, access to child care is provided, either on site or by arrangement. Similarly, the transportation needs of patients can be met through bus, train, and subway passes or tokens, or staff drivers. State licensure requirements and liability insurance are considerations in implementing these services, as is having qualified staff to provide them. Addressing these issues can have a significant impact on patient participation and retention.

Organized Recreation and Leisure Activities

OT programs can be greatly enhanced by providing therapeutic recreation and leisure activities. Optimally, programs can hire a certified recreation therapist who has specific training in teaching recreation skills, leisure activities, and stress reduction, and who can educate patients about the role of such activities as an important aspect of recovery.

The value of recreational activities include: 1) learning social skills, 2) learning cooperation and trust, 3) experiencing healthy competition and teamwork, 4) bonding with other clients, and 5) learning to have fun without the use of AODs. Recreational activities that involve physical exercise often diminish agitation, stress, anxiety, and depression; increase appetite; and enhance healthy sleep. Recreational activities include aerobic exercise, organized sports and games, assorted arts and crafts endeavors, and therapeutic participant games.

Leisure activities include taking quiet walks, reading books, engaging in conversations, watching organized sports, and being passively entertained. In an IOT program, leisure activities can teach clients that some passive experiences can be therapeutic, healthy, relaxing, and enjoyable without the use of AODs.

Transition and Continuing Care Services

IOT programs should provide extended treatment services that follow the intensive phase of treatment.

Continuing care -- often called aftercare -- is the opportunity to address treatment plan goals and objectives that were not met during the intensive phase. Such services are designed to provide clients with continuing support and opportunities for further growth and development. Continuing care is also a transition from an intensive level of treatment to nontreatment phases of recovery.

Continuing care services can include such outpatient services as case management; individual, group, or family therapy; liaison and advocacy; and monitoring and drug testing. Continuing care can also include various social activities such as recreation and leisure events and field trips. The case manager, counselor, therapist, or continuing-care-monitoring specialist can provide valuable liaison services between the patient and the employer, union, judge, or probation officer as required. Such IOT program staff can observe and document participation and progress in treatment and provide evaluations to appropriate individuals or agencies when required.

If an IOT program is not organized to offer these transitional services, appropriate referral providers should be identified and used extensively. To ensure effective continuing care, IOT programs should develop a close relationship with those providers. Reimbursement for these services may be problematic. Because of the proven value of extended treatment participation, this matter should be carefully discussed with payers.

Alumni Activities

Activities that promote continued contact of former clients with the IOT program can be of benefit to both current and former clients in the program. Individuals who have completed treatment can serve as role models and peer helpers by bringing new patients to group meetings and by organizing special recreational activities such as picnics, parties, baseball games, and drug-free outings and social activities. Alumni events can provide patients with the sense of an extended or continuing therapeutic milieu and can offer important structure and support.

Outreach

Engaging AOD patients in treatment can often be a difficult and challenging process. IOT programs should consider providing a range of outreach services designed to: 1) encourage potential clients to participate in screening and assessment efforts, 2) minimize barriers to program intake, 3) provide education and interventions to families, and 4) motivate patients to engage and participate in treatment. Outreach services include satellite programs or services provided in areas easily accessible to patients. Outreach services also include visits by IOT staff or contractors to clients' homes, work sites, detention centers, inpatient units, or jails to provide screenings and assessments and other services.

Multiple contacts with the referral sources may be needed. Outreach services may be needed for both clients and families -- including home visits when possible -- to encourage clients to come to the treatment site, begin the assessment process, and address their feelings of ambivalence and fear about changing their lives.

When planning outreach services, IOT programs must be sensitive to confidentiality issues. Under the Federal confidentiality regulations, individuals who have applied for treatment services (whether followed through or not) are considered patients. Representatives from an AOD program cannot go to a patient's home or workplace without the patient's consent if the visit would reveal to others the patient's status as an AOD abuser. AOD programs must ensure that informed consent is obtained in instances when the patient's relationship to the program can be identified. See [Chapter 7](#) for a discussion of legal issues for IOT programs.

Optimal Elements of the IOT Level of Care

- Outpatient withdrawal management
- Family, marital, or couples therapy
- Parenting skills training
- Child care and transportation services
- Organized recreation and leisure activities
- Transition and continuing care services
- Alumni activities
- Outreach.

Enhancing Services

There are several therapeutic interventions that can be valuable components of IOT programs -- as optional services that can enhance and supplement core services. Examples include:

- Structured cognitive and behavioral interventions
- "Ropes" courses
- Psychodrama

- Acupuncture
- Biofeedback
- Art therapy
- Dance and other movement therapies
- Vocational and legal assistance.

The availability of these services may depend on the specific client groups being treated, the geographic area, and funding considerations.

Clinical Challenges and Responses

While there are several advantages to IOT programs, there are specific challenges that are distinctive to the IOT level of care. The more common challenges are reviewed below and strategic responses are suggested.

Retention Problems and Relapse

Challenge. Unlike patients in residential treatment, those in IOT must make the daily decision to return to treatment. Further, IOT patients often live and work in environments in which substance abuse is prevalent and access to AODs is unconstrained. As they leave the treatment site, they may encounter environmental cues that trigger drug hunger and increase their risk for relapse. Factors contributing to client dropout include:

- Ambivalence about stopping use of the primary drug of choice
- Lack of commitment to stop all AOD use
- Crises regarding family and work responsibilities
- Denial of AOD problems or severity of the problem
- Denial that adverse consequences are caused by AOD use
- Discomfort with identity as a recovering person
- Inability to relate with others in a group setting
- Lack of family support for treatment and recovery
- Family sabotage through enabling behaviors
- Work schedule conflicts.

Clinical response. Patient dropout and relapse problems should be addressed through proactive interventions designed to engage and retain patients in treatment. Since many patients experience similar types of problems that can lead to relapse and dropout, programs should continually anticipate these problems, develop educational and therapeutic strategies to prevent them from occurring, and create specific plans to deal with them when they occur.

Many patients have been living in chaotic, high-stress, dysfunctional environments that promote isolation and distrust and encourage people to ignore their feelings and to medicate their emotions with AOD use. In contrast, IOT programs should provide an environment that is orderly and free of unnecessary stress, that encourages people to recognize and handle emotions without AOD use, and that teaches and promotes trust and interdependence.

Programs should use several techniques that encourage patients to become engaged in the treatment process and promote a sense of ownership of treatment and recovery efforts. For example, rewards can be created for perfect or excellent attendance in treatment, successful completion of treatment can be marked with ceremonial graduation events, and important treatment and recovery milestones can be acknowledged in client community meetings. Special events and activities such as staff-client skits and games can be organized and regularly scheduled. Such activities can help clients experience a sense of inclusion, belonging, interdependence, trust, openness, and emotional self-awareness.

Behavioral contracting can help improve retention. Methods include written agreements to complete the program and the use of a modified token economy point system. Programs can provide tangible incentives to foster additional motivation.

In a modified token economy system, patients earn points or recognition for such practical behaviors as arriving on time for the treatment day and attending all scheduled activities for the day. They can earn points or other recognition for completing a treatment plan objective, identifying a sponsor, completing the relapse prevention workbook, or working with the counselor to schedule a family session. In some cases, points are redeemable for bus tokens, daily meditation pamphlets, and 12-step literature that would otherwise have to be paid for (such as the "Big Book" of Alcoholics Anonymous).

Since relapse is one of the main reasons for patient dropout, IOT programs should provide clearly defined education and practice sessions on relapse prevention. These sessions should address: the process of relapse, relapse-related thinking and behavior, drug hunger triggers and subsequent responses, AOD refusal skills, and the use of self-help, recovering peers, and professional services for the prevention or curtailment of relapse.

Frequent AOD toxicology screening is recommended, particularly for clients with a history of relapse. Positive drug screenings should be immediately discussed with clients, and problem resolution strategies should follow these relapses. Aggressive encouragement of family involvement in treatment can result in: 1) active family participation, 2) family ownership of the treatment and recovery process, 3) potent family support of the client for treatment and recovery, 4) family recognition of early warning signs of relapse, and 5) unified family persuasion to remain abstinent and in treatment. These efforts help to decrease relapse and client dropout.

In group therapy sessions, excessive retelling of stories by patients about their AOD use should be prevented. Such "drugalogue" stories can glorify AOD use, generate euphoric recall, and become triggers for drug hunger and relapse. Instead, a positive therapeutic milieu can be developed to recognize and support recovery progress and to deter and confront "slips" or setbacks.

Early in the treatment process, consent should be obtained to allow the IOT program to contact clients' source of referral -- such as an employee assistance program professional or an employer, probation officer, or spouse -- so that these agencies or individuals can be contacted in the event of potential or actual departure against medical advice. AOD programs must have written consent from the client to contact the referral source; the client can verbally revoke that consent

at any time. Also, the consent form must specifically state the reason for communicating with the referral source, such as "to discuss progress in treatment." When dropouts occur, referral contacts can help apply leverage to encourage clients to immediately return to treatment.

When patients do not arrive for treatment and scheduled appointments, outreach efforts should be initiated, such as telephone calls immediately after group sessions are missed. Again, the AOD program cannot disclose any information that will reveal the name or nature of the IOT program to the individual who answers the phone unless the patient has signed a consent form for that individual. Group members may also choose to check in with missing peers, and should be encouraged to do so -- within the guidelines of confidentiality regulations.

Followup with patients who drop out of treatment should be extensive and assertive, including phone calls, letters, home visits when feasible, and other forms of outreach -- for an extended period of time.

Treatment Noncompliance

Challenge. A lack of compliance or feeble compliance with the goals and objectives of AOD treatment occurs in all types of programs at all levels of care. The flexible nature of IOT and the amount of time spent outside of a treatment environment may make treatment noncompliance easier than more intense levels of care. Resistance or ambivalence to treatment may be manifested by intermittent attendance and minimal participation, refusal to attend self-help groups, avoidance of urine drug screens, refusal to sign consents, and missed appointments.

Clinical response. A clearly delineated list of expectations must be included in the master treatment plan, signed by the client at the onset of treatment, and referred to throughout the course of treatment. Other patients can be involved in the role of peer helpers to reinforce desired behavior. Recognition of desired behavior on the part of other clients in the program is also useful as a part of this reinforcement process.

As a last resort, therapeutic discharge, in which treatment is terminated and a referral made to another program, may be considered. Whenever this mechanism is employed, however, a means should be provided for the patient to reengage in the program.

Employer Mandates

Challenge. In most instances, the involvement of a client's employer has a positive effect on the overall treatment process, especially when an employee assistance program is involved. However, there are times when employer mandates and pressures placed on the patient by the employer are counterproductive to treatment goals. Employers may be unwilling to provide a flexible work schedule to allow employees to participate in treatment. Another problem is the lack of confidentiality at the work site, a problem that can make the client a target for discrimination by peer employees.

Clinical response. In some situations, involvement of the patient's employer in the treatment plan through education and frequent contact can help to make the employer an ally in achieving

treatment goals. Again, this is especially true for clients who have an employee assistance program or similar body such as union committees. Indeed, IOT programs must be sensitive to the variation among employers and listen to patients that describe their employers as unsympathetic. At the same time, clients who have had multiple positive drug screens must be clearly told that they may face termination by the employer if the trend continues and that being in treatment is not necessarily protection against loss of employment. Utilization of employee assistance program services can greatly assist in the patient-employer relationship. Such services have clearly defined policies and provide supervisory training to business and industry.

Unhealthy Relationships Between Patients

Challenge. Most chemically dependent people come to treatment with a history of dysfunctional relationships, and the tendency to form such relationships does not automatically disappear upon entering treatment. Unhealthy and disruptive alliances, particularly romantic or intimate involvements, sometimes form among clients in a treatment program. Given the nature of the treatment environment and the emotional intensity of issues discussed in therapy groups, clients often can become intimately involved with other clients. Group therapy is inherently personal, and the risk develops for sexual relationships.

Among the problems engendered by unhealthy relationships between clients are resumption of AOD use, covering up for one another, sexual relationships, conflicts, and breaches of confidentiality. These relationships may or may not include AOD use, are nearly always brief and dysfunctional, and can lead to relapse for both individuals.

Clinical response. The therapy group can be used as a healing milieu to confront the individuals involved, but this should be done in a sensitive and cautious manner. A treatment contract can also be a useful tool to curb or prevent unhealthy alliances. As a last resort, therapeutic discharge may be considered, but patients should be confronted on a clinical level to gain an understanding of this behavior.

Recidivism

Challenge. As in any treatment setting, there may be clients admitted to IOT programs who do not gain significant benefit. Some have not made a commitment to the goals of AOD treatment and recovery, some live in extremely chaotic and dysfunctional situations, some have particularly severe AOD problems, and some have complex problems (such as combined psychiatric and AOD problems) that require clinically complex and intensive treatment.

Although these patients might derive greatest benefit from AOD treatment in a structured living environment, such resources do not always exist. Clients with these needs are at higher risk for recidivism, often with multiple admissions to the same or different programs.

Clinical response. Alterations in the treatment plan must be made according to individual clinical needs. One response to recidivism involves a tighter clinical control in the form of clearly defined admission and discharge criteria. Many patients at high risk for recidivism can benefit from contingency contracting in the form of a behavioral contract in which clearly

specified rules and responses are described in specific behavioral and measurable ways. More frequent individual sessions and increased involvement of the client's family and community support system are also helpful.

Finally, any treatment program has to honestly examine itself and determine whether it is inappropriate for a particular individual. At times it may be determined that a patient would benefit more from another type of treatment or level of care. Significant efforts must be made for appropriate placement.

Family Conflicts

Challenge. Addicted clients are often part of families that are fragmented, loosely organized, dysfunctional, and characterized by anger and conflict. Family members often have poor communication and coping skills, and may be addicted themselves.

Some families may refuse to participate in treatment, disavowing responsibility for the problem. Patients may have to contend with active AOD abuse in the family and repeated opportunities and inducements to use AODs. They may have a sense of shame or embarrassment based on criticism by other family members of the decision to seek treatment.

Clinical response. Family engagement and education should begin as early as possible in the treatment process, preferably at intake. At the onset of treatment, clients should be asked to sign a letter specifying which family members can participate in treatment sessions with them. The client must also sign consent forms that permit the representatives of the IOT program to speak with these family members about treatment participation.

IOT programs can develop creative ways to engage family members, often utilizing staff and volunteer alumni and family members of alumni. Phone calls and home visits by family members of program alumni can be particularly effective ways to engage family members in the treatment process. Some programs have a paid staff member who creates and coordinates a volunteer network of family members of alumni, especially alumni spouses. These volunteers can invite other family members to Al-Anon meetings, provide education about AOD treatment and recovery, and provide education about recovery from codependency. The volunteers can provide friendship, fellowship, and encouragement for family members to support the AOD-dependent family member's treatment and to help with family problems such as codependency.

Multifamily therapy groups and couples therapy with several couples are also effective in garnering the support of family members. These are professionally led groups in which families, spouses, and significant others are brought together, with or without the client, to openly discuss real-life issues and to explore their own history and family dynamics. Additionally, 12-step self-help groups for family members, such as Al-Anon and Nar-Anon, are free and available in most communities. Involvement with these groups should be an aspect of family treatment participation.

Arriving Intoxicated

Challenge. It is inevitable, given the lack of control over patients' behavior outside of the IOT program, that some clients will occasionally arrive at the treatment site intoxicated.

Clinical response. The initial treatment agreement should state that patients will arrive in an AOD-free state and will not be allowed to participate in group sessions or to receive other services if they arrive intoxicated. When this does occur, however, a Breathalyzer test or a urine screen should be immediately administered.

If clients are found to be legally intoxicated, program staff can request to hold their car keys. Arrangements should then be made for safe transportation home. Programs should be sensitive to safety considerations for clients and liability implications for the treatment program if intoxicated individuals are allowed to leave on their own. (See [Chapter 7](#) for a thorough discussion of legal and ethical issues.)

Indeed, programs should seek legal counsel for advice regarding the confiscation of intoxicated clients' car keys, and regarding clients who leave the IOT premises intoxicated. Some programs have a policy that involves anonymously calling the police to warn them about individuals not in a condition to drive who are nonetheless driving. They describe the car and give the license plate number and direction of travel; however, the patient's name the source of the tip, and the fact that the patient is intoxicated are not mentioned.

In the case of a belligerent or threatening client, or a client who appears to be experiencing psychedelic drug intoxication, the primary concerns should be for the safety of the individual, other patients, and staff. Staff should be trained to handle belligerent and threatening clients, and contingencies should be thought out in advance regarding containment of the individual.

Talkdown counseling should occur in areas that are quiet, with minimal stimulation, and free from interruption. However, a staff member counseling a belligerent or threatening patient should not be left alone in a closed room. Other staff members should unobtrusively monitor the proceedings.

It may be occasionally necessary to call upon law enforcement agencies to address and contain a potentially violent incident. It is not against the Federal confidentiality laws to request police help when a client has committed or threatens to commit a crime on program premises or against program personnel. Because the presence of police officers at the treatment site may be upsetting to other patients, the process by which such incidents will be handled should be negotiated with law enforcement agencies in advance.

Since the confidentiality of clients can be compromised, patients who are uninvolved with the incidents should be placed in areas that the police will not enter. Programs should establish a protocol for staff and client debriefing sessions following crisis events. These sessions will help staff with their reaction to crises, and help them assist clients with their reactions.

Managed Care and Reimbursement Restrictions

Challenge. Financial considerations often threaten a patient's ability to participate in treatment for the necessary duration of time. Unfortunately, a lack of understanding of the IOT level of care by some self-insured firms and payers, especially by managed care organizations, results in premature termination of treatment for some patients. At other times, it may not be discovered that funding is lacking until after the patient has begun treatment.

Clinical response. Every IOT program needs to have a policy regarding uncompensated care for clients who run out of funds. A clear financial assessment should be completed at intake and a contingency arranged for alternative sources of payment such as self-pay, Medicaid or Medicare, public sources, an extended payment plan, or second-party payment, such as payment by a family member.

The requirements of third-party payers or agents may have to be factored into the master treatment plan for a client whose benefit is managed. For instance, if it is known at the beginning of treatment that a client will be allowed only a certain number of sessions, an appropriate treatment plan should be established to ensure effective care within the bounds of the client's benefits.

It is never acceptable to discharge patients because of their inability to pay without arranging for treatment elsewhere. There should be no break in treatment when discharging a patient to another program. It is unacceptable for programs to abandon patients. Acceptance and admission of clients into an IOT imply responsibility for appropriate care.

Clinical Challenges in IOT Programs

- Relapse and dropout
- Treatment noncompliance
- Employer mandates
- Unhealthy relationships between clients
- Recidivism
- Family conflicts
- Arriving intoxicated
- Managed care and reimbursement restrictions.

Summary

The treatment components of an effective IOT program can be described as core, optimal, or enhancing elements. All IOT programs should provide the core treatment services of screening, assessment, treatment planning, 24-hour crisis management, pharmacotherapy, individual and group therapy, client and family education, case management, toxicology screening, and

program outcome evaluation. IOT programs that provide more than basic or minimal treatment services may include optimal treatment components such as family therapy, child care and transportation, recreation and leisure, continuing care, alumni activities, and outreach. IOT programs may provide adjunctive therapies such as psychodrama, stress reduction techniques, acupuncture, biofeedback, art therapy, and other therapeutic services.

IOT programs have numerous advantages. These include extended duration of treatment at less cost than intensive inpatient treatment, with equivalent treatment efficacy. IOT programs provide a flexibility that is beneficial to patients and staff. Clinical benefits include the daily application of learning and relapse management support. The development of IOT programs should include attention to potential problems related to retention, reimbursement, and crisis management.

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Chapter 4 -- Staffing Issues and Guidelines

As is true with all human service agencies, an intensive outpatient treatment (IOT) program for treating alcohol and other drug (AOD) disorders is only as good as its staff. A program operated by a staff that is uncoordinated and fragmented, uncooperative and independent, unsupportive and unsupported, and lacking in optimism, inspiration, and trust will foster client treatment experiences that have the same qualities. Programs that have these characteristics are unable to provide quality care.

In contrast, an AOD treatment program that is operated by a staff that is coordinated and unified, cooperative and interdependent, mutually supportive and effective at communication, and grounded in optimism, inspiration, and trust will help foster a treatment environment that is conducive to patients' biopsychosocial health. A staff and treatment program with these characteristics can typically provide exceptional treatment services.

Since AOD treatment is intrinsically demanding and stressful work, it is critical that treatment programs provide active and vigorous support for staff members. It is always the quality of the therapeutic alliance that influences patient experience and outcome. Therefore, programs must support staff in a way that allows staff to establish and maintain effective therapeutic bonds with clients.

With regard to staffing issues, intensive outpatient treatment programs have several characteristics that distinguish them from traditional outpatient treatment and medically managed inpatient programs. For example, IOT programs provide treatment to many patients who have left the heavily supervised and restricted environment of an inpatient setting for the less restricted environment of an IOT program. Potent medical, psychiatric, emotional, and social crises may have only recently occurred, and may yet be unresolved. There is not the benefit of shift staff to manage patient care, a problem that creates a great deal of pressure on IOT staff to handle extraordinary patient care issues.

IOT programs often provide services during evening and weekend hours. During periods of limited staffing, supervisors and staff must be flexible and responsive. IOT programs often have part-time staff and contract personnel, demanding special supervision to ensure continuity of services. Because of the nature of IOT programs, it is essential that staff members communicate effectively with one another. They must be able to adapt easily to changing situations.

Staff Member Roles

IOT treatment staff assignments and responsibilities vary according to the size of the individual program. In larger programs, some clinical services may be provided by specialists. In smaller programs, it is likely that some staff members will need sufficient training to provide comprehensive services.

IOT programs offering distinctive treatment components such as medically managed detoxification, family therapy, and recreation and leisure activities may require specialists such as physicians, family therapists, and certified recreation therapists.

Programs also have different sources from which to draw staff. A hospital-affiliated program, for example, can draw from the hospital's medical, nursing, social work, and other personnel. But many programs are freestanding, or affiliated with an institution without the broad range of services that a hospital can offer.

Personnel in an IOT program can be categorized into three groups:

- **Core clinical staff** provide direct client treatment services such as assessment, counseling, case management, medical examinations, crisis interventions, and nursing care, as well as clinical supervision.
- **Administrative, clerical, and support staff** perform administrative functions such as program planning, financial management, logistical support, recordkeeping, contracts management, and management of regulatory compliance.
- **Consultant and auxiliary personnel** are often outside consultants who provide a range of specialized services including vocational counseling neuropsychological testing, pastoral counseling, and HIV/AIDS education.

The professionals listed below may constitute the core clinical staff. The skills of many of these providers may overlap. For example, nurses and social workers may also serve as addiction counselors. As the AOD field progresses, less attention will be given to training orientation and membership in a particular discipline, and more to overall competency in addictions treatment. All of these staff have a vital role in the functioning of an IOT program on a full- or part-time basis:

- Medical staff include physicians such as psychiatrists, family or internal medicine specialists, addiction medicine specialists, and general practitioners; and nurses, nurse practitioners, physician assistants, and other "physician extenders" who provide medical and nursing assessments, examinations, evaluations, pharmacotherapeutic services, and clinical supervision.
- Addiction counselors provide assessments, individual and group counseling, education, case management, and transition and discharge planning.
- Social workers and other licensed professional counselors provide assessments; individual, group, and multifamily counseling and therapy; education; case management; and transition and discharge planning; they facilitate and make community linkages and provide clinical supervision.
- Psychologists provide individual and group therapy, psychological testing, neuropsychological testing, other assessments, and clinical supervision.

Core staff are often able to provide certain specialized services that may enhance the IOT program. Similarly, auxiliary or consulting staff can be used for program enhancement and may include the following:

- Vocational rehabilitation counselors
- Recreational therapists
- Art, speech, dance, and music therapists
- Nutritionists and dieticians
- HIV and AIDS specialists
- Clergy and pastoral counselors
- Literacy and general equivalency diploma (GED) instructors
- Patient advocates.

Clerical staff members have very important roles in an IOT program. Clerical and support staff are often the first individuals to have contact with potential clients. The nature of this interaction can often lead to successful client placement. Additionally, administrative staff ensure the effective logistical operation of the program. Without their participation, there would be no program. Such staff are also responsible for communicating information about the IOT program to potential patients or referral sources. These individuals should not be taken for granted and should be viewed as members of the team. It is important that they receive education and training regarding AOD abuse, the nature of the IOT program, and confidentiality regulations. They must receive appropriate levels of supervision and support.

In addition, interns and trainees can fulfill several clinical and nonclinical functions. These include physicians and medical students who are participating in an addiction medicine internship; undergraduate and graduate students in clinical psychology, counseling, social work, and addiction studies; and nurses who are participating in an addiction setting placement for a nursing specialty in addiction. Trainees and interns cannot be expected to replace paid staff or provide services that they are not qualified to provide. However, they can be valuable adjuncts to the program and should be incorporated into staff planning. Programs should have written policies and procedures for notifying patients that their care may in part be provided by interns and trainees.

Shared Knowledge and Beliefs

In addition to specific clinical skills and specialty training, all AOD treatment personnel should share common beliefs and philosophical orientations. First, they should recognize that AOD addiction is a disorder, not a problem caused by moral corruption, emotional deficits, failed willpower, or ignorance. Second, they should recognize that AOD addiction is a biopsychosocial and spiritual disorder not treated effectively or exclusively by any one discipline or orientation, but best treated by a multidisciplinary team of professionals. Third, staff should share the conviction that addiction is a treatable disorder, and that together they can successfully treat people with AOD addiction. Also, staff should share the belief that self-help groups such as the 12-step programs are vital aspects of AOD treatment and recovery.

AOD treatment staff members should be flexible and emotionally mature. They should demonstrate self-awareness, the capacity to relate effectively to others, the capacity to confront and resolve one's own difficulties, self-respect and respect for others, and the willingness to learn about and understand people with backgrounds different from their own.

AOD treatment staff should be willing to listen and understand and have a desire to learn. They should be willing to utilize supervision and mentorship and have an openness to new approaches and orientations. They should be eager to examine their own prejudices and able to avoid overidentification with clients.

Counselors and all professional IOT staff members should be familiar with the following 12 core functions of the AOD counselor:

- Screening
- Intake
- Orientation
- Assessment
- Treatment planning
- Counseling
- Therapy
- Case management
- Crisis intervention
- Patient education
- Referral and coordination
- Reporting and recordkeeping
- Consultation with other professionals with regard to patient treatment and services.

Clinical Competency Guidelines

The clinical competencies required are somewhat dependent on the specific program, and vary from program to program. In large, heavily staffed programs, not every staff member will have to possess an entire range of skills and competencies.

However, because of the complex needs of clients treated in an IOT program, staff often must be skilled in more than one area of therapeutic intervention. In smaller programs, it is particularly critical that staff members have comprehensive skills and experiences.

Evaluation and Diagnostic Skills

Staff members should have a clear understanding of the diagnostic signs and symptoms and criteria associated with AOD use disorders. They should be able to conduct a thorough psychosocial evaluation and understand that a diagnosis is not merely a label placed on a patient but a set of hypotheses about the patient's condition. They should understand that the diagnostic process is a framework for determining the problems clients have -- a framework that dictates what treatment is provided.

Staff need to be thoroughly familiar with the current version of *the Diagnostic and Statistical Manual of Mental Disorders*, ([American Psychiatric Association, 1994](#)), which continues to be the professional guide to making diagnoses and treatment decisions, and which is the standard reference for reimbursers and other professionals.

Documentation Skills

Patients' charts are legal documents and serve several important training functions. The records identify patient issues and serve as the official log to track changes, progress, and case planning. As such, they serve as a vehicle for communication among treatment providers. This is especially critical when the care of a patient is transferred to another provider.

Records are the basis for utilization review, quality assurance, program assessment, and licensure -- to ensure the continued status of the program and the ongoing care of patients. Good recordkeeping is more than a "bureaucratic obligation." It ensures that good care is being provided and records the specific impact of interventions.

For these reasons, chart documentation is a fundamental part of the responsibilities of treatment staff. Training regarding the proper and timely documentation of assessments, interventions, treatment, transition, and discharge is essential for staff at all levels of IOT programs.

Fundamental Counseling Skills

Certain fundamental and generic counseling skills are needed in all types of therapeutic interventions. These include establishing rapport and the ability to engage and align with the client. Staff and other clinicians should be genuine and nonjudgmental and should treat clients with respect. They should not be threatening and must be able to deal with clients' ambivalence about abstinence. Staff should have the characteristics and skills that relate to empathy, genuineness, respect, self-disclosure, warmth, immediacy, concreteness, confrontation, and change.

Staff should also have the ability to recognize if counseling and other therapeutic interventions are working or not, and should have an awareness of the client's reaction to the therapeutic process and of their reaction to the client. They should know when it is necessary to seek help from other professionals.

IOT patients are often newly recovering AOD abusers. It is particularly important for the staff to be able to confront them in a nonjudgmental way. Staff must be able to provide information and education despite patients' tendency to deflect information.

Staff must be aware that many therapeutic issues will not be addressed during IOT and that some issues will be addressed partially and incompletely. There may be a lack of time within a specific therapeutic intervention or within the schedule of the IOT program to address some issues fully. Also, many clients will have several problems, such as mental health needs, that require clinical attention. However, addressing some problems should be temporarily postponed until clients are stable with regard to their AOD use disorders. Thus, staff will often need to orchestrate the level

of intensity of therapeutic interventions and allow sufficient time for individual clients to reach closure on an issue (even if temporary) before the clients leave the premises.

Staff should also have the ability to integrate therapy with events occurring in their clients' lives. Staff should be comfortable becoming involved with the clients' family, employer, and community.

Staff should be able to work with a team and be willing to assume and relinquish authority when necessary. They should have appropriate training for working with people from different ethnic and cultural groups. Staff must have a commitment to using community resources, and to active networking and relationship building to develop a community network of treatment and social services.

Staff members who are recovering from AOD addiction should be trained to serve as AOD professionals. They should be educated about not overidentifying with patients. Recovering staff members should not expect a patient to respond to treatment in the same manner as they did. They need to be comfortable with a patient's developing a different set of recovery skills and resources than their own.

Individual Counseling Skills

Competencies needed for individual counseling include general listening, reflecting, paraphrasing, and solution-oriented, problem-solving skills. Staff also need the ability to establish rapport, to regulate the intensity of the session, and to manage the therapeutic boundaries of the relationship. Staff should also have the competence to recognize and resolve transference and countertransference issues and to confront denial and resistance. Staff should seek regular consultation on these issues from their supervisor.

Group Therapy Skills

Staff involved in group therapy must know the difference between group therapy and group support. They must understand the purpose of "here-and-now" group therapy and group process dynamics. They should be able to use the group to facilitate confrontation when necessary and to move the group from a psychoeducational to an interactional mode and back again when necessary. Flexibility is especially important in facilitating the interactive process.

Staff members must have the ability to structure and actively facilitate the early recovery group, until the group demonstrates the capacity to organize itself. Staff members should be able to use the group to advance the overall goals of treatment such as achieving abstinence, solving problems, improving social skills, resolving conflicts, effectively expressing emotions, developing trust, and cooperating with others.

Group counselors must understand the dynamics of addiction, especially the generally potent defense mechanisms that prompt clients to avoid rather than confront issues. Staff should be familiar with denial, minimization, resistance, projection, and other manifestations of an addicted

person's defense mechanisms, and should develop ways to address these defenses using the group process.

In contrast to other settings, IOT group facilitators should be more active, directive, and responsive to client resistance. The group must be client centered, but with the counselor playing an active role, especially early in the group's development.

The ability to manage clinically difficult patients is an important attribute. Staff are likely to encounter patients who are still using AODs, patients who are withdrawn, patients trying to take over the group, cognitively impaired patients, and patients with active psychiatric illness.

Staff should understand that change takes time. They should also know that facilitating a seemingly unproductive group session does not mean that the process is ineffective. It is also important for staff to be able to work with a cofacilitator, which involves planning and responding to the group process. Ideally, cofacilitators meet before and after group sessions to discuss the day's group experience. Because of the special advantages of two-therapist groups, cofacilitators are recommended for all outpatient groups.

Family Therapy Knowledge

Staff members who participate in family therapy sessions or multifamily therapy sessions should have knowledge of and supervised experience with systems-based family therapy methods and techniques. Family interventions are key to outpatient work. Thus, it is recommended that all IOT counselors have some contact with family work.

A traditional family therapist may work with a family once a week. In IOT, the family therapist needs to go beyond traditional frameworks of family therapy and be able to engage in a variety of other activities related to adaptive family responses to the AOD use that exists in the family. These additional interventions may include multifamily therapy, family educational services, psychodrama, or extended day family treatment services. Family therapists in the IOT setting should be trained and skilled in a variety of intervention techniques. Family specialists working with AOD clients should have a thorough knowledge of adjunct family supports such as Al-Anon and Naranon.

Case Management and Teamwork

IOT program staff members work with many other people in order to accomplish their goals. Thus, communication skills are vital. Open and regular communication among team members is crucial. There must also be communication between program staff and the other community resources that serve clients. Staff must be able to relate to medical and psychiatric staff so that they can work in concert.

The two primary functions of case management are to ensure that patients receive the services that they need -- when they need them -- and to ensure that they experience a continuity of treatment despite changes in treatment programs, changing needs for medical and social services, and other changes in their lives.

IOT staff members involved in case management must serve as liaisons among treatment providers, third-party reimbursement sources, social services, and community resources. They must have a thorough knowledge of available medical, psychological, addiction, religious, spiritual, and social services.

Multidisciplinary Teams

Because of the biopsychosocial and spiritual nature of addiction treatment and recovery, and because of the diversity of client needs, multidisciplinary teams are essential in the IOT setting. No single profession incorporates the breadth and depth of resources and skills needed to adequately address the wide range of issues of IOT clients and their families.

Staffing should be based on an appreciation of the philosophy of the multidisciplinary team approach and a respect for all disciplines and their contribution to the treatment process. The size of teams varies according to the facility, but the following services should be included in some way:

- Medical services
- Counseling
- Case management
- Social and family services
- Psychological services
- Psychiatric services
- Other ancillary services.

Decisionmaking in the treatment of the IOT patient should be a group endeavor, where input from the various disciplines is considered in assessing progress in recovery. The team is the unit that will assess and chart progress and do treatment planning. The team should function cooperatively, with open communication, with the best interests of clients always being the focus.

The team should have regularly scheduled meetings. Also, ongoing communication among team members outside of formal meetings is critical, especially since some patients' problems require immediate or rapid resolution.

Working Knowledge of Self-Help Programs

Staff in IOT programs should understand the philosophy of 12-step and other self-help programs, how these programs work, and how they relate to IOT treatment services and any other treatment in which the client may become involved. Besides understanding the philosophy, purpose, and function of self-help programs, they must understand several practical issues. These include:

- The common resistances that people have to participation in 12-step and other groups
- A knowledge of local meetings so that patients can be referred to groups that meet their individual needs
- The function and importance of sponsorship and how to incorporate sponsorship-seeking in the treatment plan

- The differences among 12-step group meetings, such as open and closed meetings, speaker and step meetings, nonsmoking meetings, and meetings for people from special groups, such as men, women, gay men, lesbians, and youth.

There are important distinctions between professional AOD treatment and nonprofessional adjuncts to treatment such as the self-help groups. Professional staff must be able to understand them and to explain these differences to a client.

Crisis Management

Crisis management is one of the core functions of AOD counselors, a function that is particularly pertinent to the special needs of patients in an IOT program. It can be approached in two ways: staff members can have the crisis response skills necessary to handle a crisis themselves or they can develop the necessary community relations to rapidly obtain the appropriate resources as soon as a crisis develops or seems imminent. Both approaches should be a part of IOT staff training in crisis management.

The ability to manage a crisis should be considered when hiring personnel for the IOT setting. Necessary skills include sound judgment; the ability to think, assess, and respond appropriately; and the ability to assess and stabilize a psychological, social, or medical crisis. Sometimes the skill required is as simple as knowing when to call 911. Other important traits are knowing how to stay out of dangerous situations, knowing when to let go of an issue if a potential crisis is escalating, and understanding one's personal limitations.

Programs should have an explicit written protocol about handling crisis situations. All staff members should be familiar with the protocol.

Ethical Guidelines

Adherence to professional ethics is important for staff members of all intensive outpatient treatment programs. Personnel working in IOT settings should have a demonstrated commitment to the ethical standards of their profession.

Each individual profession represented in IOT has its own professional code of ethics, and these form the basis for identifying and managing ethical issues. Within the complex IOT context, it is important that counselors and other professionals not go beyond the bounds of their training and experience in the services they provide. Another important point to emphasize is that staff are expected to adhere to ethical standards regarding contact with clients. There should be clear program guidelines on staff contact with patients outside the program since it is inevitable that staff will see clients away from the program. This may be particularly likely for staff who participate in community self-help groups.

Because of the open and unstructured nature of IOT, and the necessity to sometimes work in isolated settings, counselors may be particularly susceptible to charges of misconduct. The program must have clearly stated ethical standards of staff-patient relationships. Whenever possible, at least two staff members should be on site whenever patients are present.

The program must have a protocol for reviewing untoward incidents or complaints and for documenting reports. These incidents must be handled immediately after they happen.

Staffing Level Guidelines

Because IOT programs vary widely, it is impractical to state specific guidelines for staffing levels or patient-to-staff ratios. However, it is equally important to emphasize that staff in an effective IOT program must be capable of providing intensive, high-level, and responsive services. IOT needs clearly differ from those of other programs with respect to staffing levels. AOD patients have traditionally been served in inpatient facilities, with 24-hour coverage and the support staff associated with an inpatient setting. Although IOT programs require lower staff-patient ratios than outpatient programs that are less group oriented and less structured, there should be sufficient staffing to ensure that no client will go unnoticed and unattended. This is especially critical with respect to the particular challenges cited in [Chapter 3](#). This consideration to patient care should be given within the context of what staff can reasonably accomplish within the parameters of the paid work schedule. For example, a 20-hour part-time employee should not be given caseload responsibilities requiring 40 hours.

A number of variables should be considered in establishing counselor caseloads, including the type of care provided and the availability of auxiliary services. Some States may have regulations governing staff-to-client ratios. These issues must be addressed on a program-by-program basis.

A program should establish clear standards associated with clinical care time to support task rates. A proposed ratio for primary therapists is 50-50: 50 percent of their time engaged in clinical patient contact, and the other 50 percent doing support work related to patient services, such as recordkeeping and community networking. This ratio should be applied to clinical work only, not to supervision or other work clinicians might sometimes perform.

Establishing an ideal time-use ratio is recommended for staff well-being and burnout prevention. However, considering the intense needs of IOT clients, this is an ideal that frequently cannot be met because considerable time is often spent in direct patient care. The size of the IOT program staff, the clinical needs of patients, and the availability of backup services must all be factored into this formula.

Staff Stressors

IOT work and the nature of the population being treated can cause significant stress among staff. This stress can sometimes be an impediment to running the program successfully. Training front-line and supervisory staff about these stressors can help diminish some problems and help staff prevent or effectively address other problems as they arise.

Staff in different programs will face different dilemmas, and each program must develop its own way of dealing with stressors. In all but the smallest programs, regular meetings to process the concerns of staff members are recommended. Regular meetings should also be held to address

the problems of support personnel, who may face different stressors -- sometimes because of the pressures placed on clinical staff. Problems should be addressed as early as possible.

For example, holding a meeting at the end of a stressful day allows staff members to communicate their feelings and express problems and complaints before another work day begins. Staff members should be encouraged to ask for such meetings whenever there is a need.

Some significant stressors that should be anticipated include:

- **Long hours and inconsistent work schedule.** The demands of clinical coverage in IOT programs often involve evening and weekend hours for virtually all staff members, which can result in staff members feeling isolated from colleagues and support services. Sometimes staff members are required to work broken day shifts, which, like evening and weekend schedules, can interfere with family life.
- **Demands of an AOD treatment population.** The acute manifestations of AOD abuse and the stress faced by clients, their high risk for crises and sometimes unpredictable behavior, and the intense nature of the treatment environment can create significant stress for counselors and other staff members. The infrequent opportunities for staff members to share their experiences with other peers can lead to isolation, frustration, anger, fatigue, and a sometimes overwhelming sense of responsibility and feelings of helplessness.
- **Large caseloads.** IOT programs often require a lower staff-to-patient ratio than other outpatient programs. High caseloads can be detrimental to the program. Having smaller caseloads can prevent staff members from being overwhelmed by the demands of the job. This is especially critical in many programs that have to operate with smaller staffs than they actually need.
- **Time involvement.** Extensive case management time and effort are needed because of the complex issues and needs of AOD clients. These include patient retention efforts and networking with other providers, including employee assistance programs and employers, social service agencies, mental health care providers, and the criminal justice

system. Issues such as relapse, patient employment problems, psychosocial conflicts, after-hours crises, and family problems often complicate treatment and must be handled by the treatment team.

- **Limited resources.** Limited community resources and supports further complicate treatment in some areas. Clinical staff are required to make extra efforts for nontraditional AOD abuse treatment tasks, which can include vocational placement, housing assistance, and transportation assistance.
- **Coordination with managed care providers.** Coordinating treatment with managed care providers is a recent addition to some counselors' job descriptions. This responsibility can be an additional stressor. Staff members may feel that pressures from managed care providers conflict with efforts to help patients, and reimbursement may be exhausted long before the counselor feels the treatment process should be concluded.

Some of these stressors can be addressed by the team approach, which can promote shared responsibility and personal support. It is imperative to have a full spectrum of clinical support services available on short notice, and it is also imperative that clinicians know when and whom to ask for help.

IOT Staff Stressors

- Long hours and inconsistent schedule
- Client demands
- Large caseloads
- Extensive time involvement
- Limited resources
- Coordination with managed care.

Recommended Staff Supports

Stresses involved with IOT work are significant and should not be underestimated. However, they can be resolved, and programs can develop a work culture and personnel policies and procedures that enhance staff retention, avoid burnout, and keep the program functioning at a level that provides high-quality care.

It is important to note that a program should be committed to having as much regard for its staff members as it does for its clients. Again, the most essential and indispensable resource of a program is its staff.

Program Philosophy and Description

As discussed above, a fundamental aspect of an effective treatment program is the establishment of a program philosophy and a description of the population served and how the program serves it. The program philosophy and description should incorporate a clear mission statement, congruent with the day-to-day practice of the program.

This written document relates to staff performance and expectations because it defines standards for effective and ethical treatment interventions, and it defines the relationship between clinician and client. It provides boundaries for counselors. The program philosophy should provide standards and guidelines for the well-being of staff, and support the staff by giving them clear guidelines and goals for acceptable and desired standards of care and defined roles.

IOT is community-based treatment, and the program statement should address professional relationships within the community, as well as the purpose of treatment, expected outcomes, and strategies for accomplishing these objectives. The philosophy gives the program a clear sense of what it is supposed to do and expresses its reason for being.

The philosophy and program statement should be a dynamic document and should be regularly reviewed and discussed, since a program is constantly developing, changing, and adding new staff. It should be flexible enough to be open to new input at any time, and all staff members should be encouraged to contribute to it on an ongoing basis.

Job Description

It is important that all permanent and auxiliary clinical and administrative staff members have a clear and complete job description that includes job expectations, responsibilities, and specific functions. Job descriptions should be the basis for performance evaluations, with clearly defined expectations and performance levels. These performance indicators should be measurable and should change as the responsibilities of the program and the capabilities of the staff change.

Shared Ownership

Shared ownership of the program is an important concept that empowers staff members by having them share accountability for the program. This means that all staff feel credited when the program succeeds and that everyone participates in its development and operation. Management in such a setting is participatory rather than hierarchical. Shared ownership protects the integrity of the program.

Situational methods such as program retreats or planning sessions should be established to allow staff to have responsibility for input into program design and development. Support to the staff can be further realized by extending the ownership of the program to the patients it serves by offering a strong therapeutic involvement (e.g., the use of multifamily therapy groups). Strong patient involvement enhances clinical responsiveness while reducing patient reliance on staff.

Appropriate Recognition

Another important staff support is appropriate recognition, which should occur at all levels. Good management means acknowledging successes as well as shortcomings. This is a skill that every supervisor should have, to avoid being solely problem centered. IOT supervisors should be skilled at recognizing staff effort and accomplishments outside of the normal appraisal process. The supervisor should acknowledge work well done at times other than performance review time.

Promotion

Another form of recognition is promotion. Managers should be encouraged to promote from within whenever possible. They should actively encourage employees to continue their education and should facilitate these efforts by posting information about educational programs and events and providing a reasonable subsidy for participation in them. Staff should be made aware of the potential for advancement within the program or in other settings if exceptional opportunities exist. Employees should be valued for their potential as well as their actual contribution to a program.

Appropriate Compensation

Fair and competitive compensation for a job is an appreciated means of staff support from the employee point of view. Even though there may currently be a larger pool of human resources

than positions in the field, it is important that people be paid an adequate and reasonable wage that is commensurate with their experience and qualifications.

Establishing commensurate levels of compensation cannot be adequately addressed in this document. Pay scales vary widely from region to region across the country. A program has the responsibility to hire someone who is adequately trained, and compensate that person appropriately, consistent with the competitive context of the position and the compensation available for similar positions in other programs. Such actions are not only in the interest of the employee, but also in the long-term interest of the clients and the program.

A certain level of salary does not guarantee a competent staff or effective treatment, but if people are paid below community and professional standards, or are exploited, they will not likely remain with the program. Frequent employee turnover is a sign of poor personnel practices.

Flexible Work Schedules

In an IOT setting, the commitment to flexible work schedules is critical to recruiting and retaining good staff. Flexible work schedules can help staff members accommodate their personal needs and make stronger commitments to the demands of the job. Whenever possible, schedules should be open to change and negotiation. Supervisors should be sensitive to the difficulties of single parents and other family issues and to other personal considerations that make a difference in staff morale. Larger programs may be better equipped than smaller ones to offer flexibility and rotating responsibilities. Flexible schedules are also particularly relevant to IOT programs that use part-time and/or contractual help. The nature of IOT work, which requires evening and weekend staff coverage, can add to the flexibility of scheduling that a staff member may find personally helpful. For example, some employees with children may prefer evening and weekend work, so that they can share child care responsibilities with a spouse who has a conventional work schedule.

This flexibility, of course, must be balanced with the needs of the program. But often what works best for the individual employee works best for the program.

Ongoing Supervision and Training

Ongoing supervision and training are also recommended staff supports. Supervision must be consistent and regular, on both individual and group levels. Clinical supervision for most staff should be scheduled at least once a week, with a clinician with qualified clinical and supervisory experience, plus additional sessions on an as-needed basis. Special attention should be paid to the supervision of part-time staff, who depend on the supervisory process to ensure continuity of services.

Staff development opportunities should be available as much as possible, allowing professional personal leave days to participate in workshops, training sessions, and other professional activities. Support for staff training should be considered in the development of the program budget, and a reasonable allocation should be given to professional development activities. The 1993 Substance Abuse Prevention and Treatment Block Grant requirements include mandates

requiring entities receiving funds to provide continuing education to staff appropriate to the services that they provide. The focus of professional development activities should be on learning new information and skills that might lead to program enhancement and more broadly focused care and competency. Given the nature of IOT, staff efforts to participate in activities such as stress management workshops should be encouraged.

Supporting IOT Staff

- Provide a clear program philosophy and description
 - Encourage shared ownership of the program
 - Provide appropriate staff recognition (promotion and compensation)
 - Allow flexible work schedules
 - Provide ongoing supervision and training
 - Encourage team building
 - Encourage peer assistance.
-

An important part of staff training is attention to culturally sensitive issues. All programs should have a commitment to provide this training. Culturally diverse groups and issues include:

- Gender issues
- Age issues
- People from lower socioeconomic backgrounds, including homeless persons and those with housing instability
- Rural and urban populations
- African Americans
- Hispanic people
- Native Americans
- Asians and Pacific Islanders
- Asian Americans
- Gay men
- Lesbians
- Physically challenged people.

[Exhibit 4-1](#) is a list of written materials and sources for information about cultural sensitivity training.

Team Building

An organized approach to team building is another helpful way to support IOT staff. It is helpful to have daily processing time for counselors to discuss and analyze the clinical events of the day, particularly after any untoward incident.

Regular retreat sessions are a valuable way of getting away from the stress of the job and concentrating on planning and program evaluation. A retreat also reinforces employees as stakeholders of the program, involved in participatory management and decisionmaking.

Other planned events such as picnics, holiday parties, and structured activities can boost employee morale. However, these social events do not replace the need for ongoing communication and team building throughout the year.

Peer Assistance

It is also helpful for intensive outpatient treatment programs to have a peer assistance structure to deal with problems such as tragedies on the job. Encouraging peer support, both formally through regular staff meetings to discuss problems and issues and informally by creating a working team, is an important element of an effective program. The promotion of staff wellness should be a priority for IOT programs. In organizations that have them, employee assistance programs can assist staff with the resolution of personal or professional problems.

Certification and Credentialing

Every program should recognize a certifying body for professional staff, and staff should have a professional development plan. This will ensure compliance with internal privileging standards and those of credentialing bodies such as the National Association of Alcohol and Drug Abuse Counselors, the American Society of Addiction Medicine, and others.

It is also recommended that professionals who are working in the AOD field, irrespective of their specific discipline or the amount of time in AOD treatment settings, receive ongoing training in the treatment of AOD disorders. If the IOT program is the primary setting in which they are working, staff professionals need more than just a working knowledge of the field; they should be able to formally demonstrate AOD treatment competency.

Recommendations

Regarding the critical issue of staffing IOT programs for AOD treatment, the consensus panel offers the following recommendations:

1. Clinical staff should be knowledgeable about the full spectrum of AOD abuse and addiction. Clinical staff should be certified or licensed, or working toward certification or licensure in their discipline, with special attention given to specific training in the addiction field.
2. The IOT program should be run by a core of clinical staff members who each identify the program as his or her primary job. Although part-time employees are part of many programs, an IOT program should not be run exclusively with them unless it serves a very small or specialized population. The program usually needs a core full-time staff that is responsible for maintaining the continuity of care that the program provides.
3. Ongoing quality supervision that is responsive to the needs of the clinical staff is an important part of the IOT program. Part-time personnel require consistent supervision to ensure adequate support and guidance and consistency of services.

4. Those charged with certain responsibilities should have the authority and resources to successfully meet the expectations of their jobs.
5. Any consideration of IOT staffing must respect the unique stressors and challenges faced by IOT staff, such as working odd hours, working in isolation, and a lack of "third shift" support.
6. Quality IOT programming must be done within the context of multidisciplinary teams.
7. The clinical staff should not be utilized in functions that limit or detract from their ability to provide optimal care for their clients.

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Chapter 5 -- The Treatment Needs Of Special Groups

Several groups of patients receiving treatment for alcohol and other drug (AOD) use disorders may have distinctive treatment needs. These groups are numerous and include:

- Women -- particularly pregnant women and women with children
- People from minority ethnic and cultural groups
- People with combined psychiatric and AOD disorders
- People who are homeless or who experience housing instability
- People with HIV infection or AIDS
- Gay men and lesbians
- Elderly people
- People involved with the criminal justice system.

While patients from a specific group may have several treatment needs in common with other members of that group, each patient should be considered and treated as an individual with a distinctive set of treatment needs. Thus, the development of individualized treatment plans should include the consideration of issues that are associated with special group status.

Because treatment resources are limited, patients with special needs usually are integrated into generic intensive outpatient treatment (IOT) programs. The following common or overriding themes emerge regarding the treatment of special groups, both at a clinical and at an administrative level:

- At a clinical level, client-counselor matching can be important. Although not consistently or empirically demonstrated, matching should be made along sociocultural lines whenever clinically appropriate and possible.
- Educational and support groups and other programming designed to address special needs should be developed. This may include a single, specialized, weekly group during the standard program, a specialized treatment track with a series of coordinated services, or a separate dedicated program that serves only the target group.
- The program mission and philosophy must reflect an openness and support for the diversity represented in special groups. Ideally, the mission statement should be developed with input from representatives of the special groups.
- Program staff training should be designed to develop staff competency in recognizing, supporting, and addressing the needs of special patient groups.
- Community involvement in program goal development, networking, and patient entry and retention are critical to the overall effectiveness of IOT.

- Family members, patients' partners, and other significant others should be actively involved in treatment. Program staff should be sensitive to cultural, ethnic, and regional variations in family structures and the way that patients define their family.

These broad issues will be further addressed within the following sections on each special group. It will become apparent throughout this chapter that IOT programs may be especially suited to the treatment of some special population members because of the range and severity of treatment needs that can be met in the IOT programs, as well as the availability of internal and external supports in many regions of the country.

Whether these treatment needs can best be addressed within generic programs that have services for specific groups or within programs that serve only the specific groups is a complex issue. A variety of factors influence decisions regarding the best placement.

Practically, these decisions may have to be based on the financial realities of the program and the volume of patients available to participate in a specialized program. Clinically, such decisions may be influenced by the perceived severity and uniqueness of the treatment needs of the target group. Similarly, these decisions may be influenced by the extent to which special groups can benefit from specialized care and to what extent such services can be offered without detracting from the services provided to other patients.

When the decision is based on the goals of recognition, appreciation, and promotion of the diversity represented by the target group, such programming may prove highly effective for patients and their respective communities.

The special groups identified in this chapter do not constitute an all-inclusive listing of groups with special treatment needs. Rather, this TIP addresses the needs of special groups that are most likely to be served by IOT programs. Readers who want information that will more intensively address the treatment needs of these and other special groups are recommended to review the bibliography in the [appendix](#) of this TIP, as well as the TIPs on *Treatment of Alcohol- and Other Drug-Abusing Adolescents; Pregnant, Substance-Using Women; and Improving Treatment for Drug-Exposed Infants*.

A Note About the Family

IOT program staff and program mission statements should understand and embrace definitions of the family as described by patients. While one definition of the family is a group of people who are related by birth and marriage, there are many other definitions that are broader in scope and influenced by ethnic, cultural, and regional factors.

For these reasons, IOT program staff and program philosophy should acknowledge and accept patients' perspectives regarding what constitutes a family. In a general way, the family can be understood as a primary group whose members assume certain obligations for each other and often share common residences.

For instance, the National Association of Social Workers Commission on Families defines the family as two or more people who consider themselves family and who assume obligations, functions, and responsibilities generally essential to healthy family life. The functions of family life include such functions as child care, child socialization, income support, long-term care, and other types of caregiving.

Thus, it is important for IOT programs to be flexible when addressing family issues. Some definitions of families are: 1) a mother and her child; 2) a wife, husband, and children; 3) a woman, her children, and ex-husband; 4) a large extended group that includes relatives and close friends; 5) same-sex couples; 6) an individual with a domestic partner; and 7) a woman and her significant other; and 8) relationships such as grandparent and grandchild.

Women

Women often require specialized or enhanced medical, psychosocial, family, peer support, and other services. These services are often unavailable or partially available in traditional AOD programs in which women typically represent a minority of the patient population. This has led to the increasing development of specialized women's services within mixed-gender settings and the development of separate women's programs. Although not addressed in this TIP, consideration should be given to the development of men's groups.

Because of the extended clinical contact that IOT programs can provide -- compared with traditional outpatient programs -- they offer an opportunity to address a variety of women's needs. Ideally, IOT programs should be able to offer a full, self-contained women's program. At a minimum, women-only groups should be offered within the mixed-gender setting. Also, IOT program providers should be sensitive to gender matching in making counselor assignments.

At the same time, IOT staff should recognize that women are not a homogeneous group. Female patients have a variety of different treatment and psychosocial needs, influenced strongly by their backgrounds, experiences, and AOD problems. For instance, single career-oriented women without children may feel that their needs are more similar to career-oriented men and women than to single mothers -- who may perceive that child care, transportation, and help with parenting are their most pressing needs. Although all women will have gender-related concerns, the assessment process should identify which women or men may benefit most from mixed-gender treatment or separate women-oriented treatment. It should not be assumed that the needs of women and children are the same, although they are frequently linked together by policymakers.

Enrollment Issues

The social stigma associated with AOD abuse inhibits women, more than men, from seeking addiction treatment ([Weisner and Schmidt, 1992](#)). Also, women are more likely than men to define addiction-related problems in terms of health and mental health, while men are more likely than women to describe their addiction-related problems as explicitly AOD-related ([Thom, 1986](#)). Thus, women are more likely than men to seek treatment for the health or behavioral components of AOD use rather than specialized AOD abuse treatment. This may lead women to

obtain treatment later in the course of their illness, perhaps at a point when their problems are more severe than those of many men who obtain care ([Beckman and Amaro, 1986](#); [Blume, 1986](#); [Furst et al., 1981](#); [Horn and Wanberg, 1970](#)).

Although studies of the general population typically report higher rates of AOD abuse problems among men than among women, some recent longitudinal studies suggest that gender differences related to alcohol consumption are beginning to converge, with disproportionately high rates of problem drinking in younger cohorts of women. Despite this, male-to-female ratios in alcoholism treatment programs have remained fairly consistent at 4 to 1.

Similarly, research suggests that women may be underrepresented in traditional outpatient and inpatient treatment settings relative to the extent of AOD problems in the general population ([Institute of Medicine, 1990](#)). This problem may be even more acute for minority women than for other women. This underrepresentation has been attributed to a number of treatment-entry barriers that may be distinctive to women, including financial limitations, inaccessibility of child care, and lack of services tailored to their specific needs ([Beckman and Amaro, 1986](#); [Blume, 1986](#); [Institute of Medicine, 1990](#); [Reed, 1987](#); [Roman, 1988](#)).

If AOD providers are to be successful in attracting and retaining women in treatment, these barriers must be reduced or eliminated. IOT treatment settings may offer special advantages with regard to flexibility of programming, minimal disruption to other life commitments, and a reduced experience of stigma.

Advocacy

There is a particular need for strong advocacy in developing IOT programs for women. Women often experience increased social stigmatization as a result of their AOD use. Such stigmatization may discourage a woman from identifying herself as an AOD abuser, and may prevent others within the medical, social services, and religious communities from identifying the problem. IOT programs should develop targeted outreach campaigns to improve program recognition, highlight the variety of services available within the setting, and encourage referral of women.

Child Care

For some women, the threat or perceived threat of losing custody of their children is a deterrent to residential treatment participation. IOT offers the advantage of intensive treatment without removing a mother from her home. Thus, the availability of child care services can be critical to the ability of women to enter and remain consistently active in treatment. Women with children are much more likely to participate in IOT if they know their children are well cared for and safe. For example, a single mother who does not have an extended family or other means of child care might not be able to sustain her IOT involvement without child care.

At a minimum, linkages with local day care programs for child care should be considered. In the ideal IOT program, services are provided on site. The full-day schedule in some IOT programs may make the development of an onsite day care program feasible and cost-effective. However, the inability to provide child care should not be a deterrent to offering IOT to women, since

opportunities may develop to add such services through grant funding or budget expansion. Programs can solicit the help of community volunteer organizations for help with child care. In these instances, special care should be exercised to protect the provider's liability and to ensure compliance with Federal confidentiality regulations.

Flexible Programming

Optimally, IOT programs for women should offer both daytime and evening treatment. While many women prefer daytime treatment because of the greater ease of meeting child care needs, the availability of evening services may make it possible for working women to take part in IOT. Family members and patients' partners may be available in some cases during evening hours, and their cooperation with the program should be considered in organizing child care arrangements.

Safe Houses or Transitional Living Arrangements

Women sometimes experience homelessness or housing instability as a result of AOD-related and non-AOD-related issues. For example, there is evidence that AOD-abusing women are more often abandoned by their spouses or partners than are AOD-abusing men. Some women become homeless because they have limited employment skills and/or may be unable to work because of child care responsibilities. Also, because of the high incidence of physical and sexual abuse among AOD-abusing women, they may find themselves seeking alternative safe shelter away from their spouse or partner. Thus, the ability of an IOT program to offer services that relate to meeting their housing needs can help a program attract and retain women in AOD treatment.

This task is at times made more difficult by the reluctance of women's housing programs to accept women who are AOD abusers. As a result, specialized transitional living facilities are sometimes needed for this group.

IOT programs that can align themselves with safe houses or other transitional living arrangements offer an important group of services that are often needed by AOD-abusing women. Ideally, such housing programs allow children to continue to reside with their mothers. Onsite staff can offer limited evening and weekend programming, while also ensuring the safety and drug-free integrity of the housing facility. Ideally, services should be available over several months to allow the woman's recovery and social problems to stabilize.

Transportation

Lack of transportation to treatment may be a barrier to participation in IOT programs. IOT programs should be sensitive to this issue, and should carefully consider the location of the program in relation to public transportation. Optimally, programs should provide assistance such as bus passes, tokens, and stipends to cover travel expenses, provide direct transportation, or help organize car pools.

Meals

Programs should also consider providing meals. This may serve several functions, including attracting women AOD abusers into care, ensuring that their nutritional needs are met, and introducing patients to meal preparation skills. It can also provide an opportunity for social support, healthy bonding, and drug-free companionship.

Medical Care

In general, the medical needs of women AOD abusers are undermet. Often, AOD-abusing women experience more severe and more varied medical problems than AOD-abusing men. For example, following the onset of heavy drinking, women are known to develop alcohol-related liver disease more rapidly than men. Women also experience a variety of other general medical problems including infections, anemia, sexually transmitted diseases (especially gonorrhea, trichomonas, syphilis, and chlamydia), hepatitis, and urinary tract infections. Also, AOD-abusing women often report gynecological problems including amenorrhea (the temporary absence of menstrual flow) and decreased fertility, which require special attention.

It is critical that the distinctive and varied medical needs of women be addressed in IOT. At present, these needs are often met through piecemeal relationships between IOT programs and other aspects of the health care system, rather than through integration of medical services into the IOT programs themselves. One way to formalize health care services is through contracting and by having explicit referral protocols.

It is vital that IOT programs establish strong, active, and formal linkages with local and accessible health care services. At a minimum, these services must include basic health care, STD treatment, and immunization of children. For example, a cooperative agreement can be developed with a local community health center. Such an agreement can specify arrangements to promote prompt service delivery and continuity of care. If there is sufficient referral volume, appointment slots can be reserved for program patients, and a relationship can be developed with a single or small number of health care providers. Also, such an agreement should stipulate that written documentation of provided services, medications, and followup recommendations be provided to IOT program staff with appropriate patient consent. This will ensure the integration of medical needs into the treatment planning process and allow program staff to facilitate the patient's compliance with ongoing care. Such a connection with health care services can enhance patient retention in both IOT and health care services.

Optimally, IOT programs should have onsite medical care. Services should include those of a family practitioner or internist to address general health needs and an obstetrician/gynecologist to address the more specialized reproductive health needs of women. Also, for programs that provide onsite day care, referral for medical, psychological, and developmental assessments of infants and children should be available. Onsite day care programs often have licensure requirements regarding referrals for assessments.

Psychiatric Care

Certain psychiatric disorders are more prevalent among female AOD abusers than among male AOD abusers, or females in the general population. For example, while rates of depressive disorders for male alcoholics are comparable to the rates for males in the general population, female alcoholics are more likely to have a diagnosis of depression than either women in the general population or male alcoholics. Female alcoholics have also been found to have elevated rates of abuse of other drugs and phobic and panic disorders. It has also been observed that women experience a slower recovery from depression than men following the cessation of AOD use.

Women patients with dual disorders may benefit from a variety of treatment services including pharmacotherapy, psychotherapy, and close monitoring. Ideally, a licensed mental health clinician such as a social worker, psychiatric nurse, or a psychiatrist should be included on the IOT treatment team to fully integrate patient care. However, it is not always possible for IOT programs to provide such treatment services on site, and certain crises require aggressive psychiatric intervention. Thus, IOT programs should establish close working relationships with community mental health programs and other psychiatric services. The access to and availability of a psychiatrist is essential for consultation and medication evaluation and monitoring. Treatment services for patients with dual disorders are further discussed later in this chapter. Indeed, treatment issues relating to patients with dual disorders are discussed in great detail in another CSAT Treatment Improvement Protocol, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*.

Abuse Issues

Women AOD abusers report higher rates of physical and sexual abuse than the general population ([Blume, 1986](#)). Abuse should be assessed across a wide spectrum: sexual, physical, and emotional abuse. For example, evidence suggests that alcoholic women are more likely than nonalcoholic women to have been sexually abused in childhood.

Managing issues of sexual abuse in IOT programs can be challenging. Because of the special treatment needs of people who have been abused, it is often best to contract with a specialized consultant to provide these treatment services. If such an ongoing relationship is not financially possible, one or more staff members should receive intensive specialized training in this area. IOT program administrators should be careful in describing program services offered to female abuse survivors. For example, some IOT programs may feel it is preferable to describe an abuse treatment component as a "domestic violence group" or "surviving abuse group," rather than a "sexual assault group" to avoid labeling women as victims.

When providing treatment services for women who have been abused, it is important that IOT programs create an atmosphere in which women feel comfortable and will join and regularly participate in treatment services. It is also important to consider the timing of these services to enhance the therapeutic value and to diminish iatrogenic or clinician-induced problems. For example, women should not be rushed into divulging a history of abuse or receive treatment for abuse problems early in the AOD treatment process. Rather, clinicians should first establish that

patients are comfortable with the idea of getting help for abuse issues and are ready to benefit from it, before they receive treatment services for abuse.

Service providers should be sensitive to the fact that some women who have been abused may be uncomfortable interacting with male staff members as a result of earlier painful relationships. Finally, it may be worthwhile to reevaluate other female patients for physical and sexual abuse history following AOD treatment stabilization, since disclosure of such personal issues is sometimes withheld until the patient is more comfortable in treatment.

Emotional Issues

Treatment needs of women with AOD problems are different from those of men with respect to several emotional issues ([Unterberger, 1989](#)). For example, AOD-abusing women are more likely to experience low self-esteem than their male counterparts. AOD-abusing women with low self-esteem may experience episodes of depression and self-derogation that, for some, may lead to a feeling of purposelessness in life. More often than men, women AOD abusers direct their anger at themselves rather than at others, prompting anxiety and guilt.

It is important that IOT programs include women-only therapy groups that specifically address the relationships between emotional issues (such as self-esteem, shame, anger, and guilt) and AOD abuse and recovery. Programs can provide communication skills education, empowerment sessions, and assertiveness training. Expressive and nonverbal techniques, including art therapy, dance therapy, and other creative therapies may be useful in the development of self-esteem and the appropriate expression of emotions.

Family Issues

Family involvement should be an integral component of IOT for women. Typically, family members have a poor understanding of the dynamics of addiction and can become barriers to successful addiction treatment and recovery.

Many family members are weary of the addicted family member's AOD problems, are frustrated because of past unsuccessful attempts to resolve the problems, and may feel reluctant to participate in treatment due to lack of optimism about the chance for success. Family members often need to learn that addiction is a treatable disorder and that treatment can work. They also need to learn that treatment is more likely to be successful if the entire family participates in and supports the addicted family member's treatment and recovery efforts.

Family members should also learn that they may have significant problems (such as anger, shame, guilt, resentment, or codependency) that relate to the addicted family member's AOD problems. They should be encouraged to identify and receive formal help for these problems. Family members should also learn that: 1) the resolution of the addicted family member's AOD problems does not ensure resolution of other family members' problems; and 2) family members can receive treatment for their problems whether or not the addicted family member's AOD problems are resolved.

The identification and engagement of appropriate family members and close friends who are still involved with the patient are often critical for successful treatment of the woman and her family.

Active addiction often prompts poor and inconsistent parenting, which in turn promotes discord, miscommunication, and family dysfunction. Thus, addressing parenting skills during AOD treatment can be a therapeutic strategy that helps encourage family harmony, good communication, and the promotion of health. Such programming may include identification of age-appropriate behavior and developmental milestones in children, nutrition education, and appropriate forms of discipline for children. One particularly important parenting skill is effective communication with children regarding the parent's addiction and recovery.

Self-Help and Peer Support Groups

Self-Help

Self-help groups, including mixed-gender and women-only 12-step groups, are important components of IOT. In some localities, certain Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous group meetings are targeted to women only. In larger cities, there are one or more Alcoholics Anonymous and Narcotics Anonymous meetings for women every day or evening. However, women-only meetings may not be available in some areas, and IOT programs can fill the gap by sponsoring women-only 12-step meetings on site.

Where available, and depending upon the patient population, some IOT programs may also want to recommend Methadone Anonymous for women. It is easier to get Methadone Anonymous groups started in IOT programs when there are large numbers of women enrolled in methadone programs. Such institutional meetings -- public 12-step program group meetings held on the premises of a treatment program -- can be initiated by having alumni or other recovering individuals contact the appropriate 12-step group and create a new meeting. The new meeting will subsequently be listed in the local directory of meetings.

Another resource that is available in many areas of the country is Women for Sobriety. This self-help organization has adopted a set of principles that specifically address women's recovery needs through a monthly newsletter, information and referrals, phone support, group meetings, pen pals, conferences, and group development guidelines. Women for Sobriety addresses sobriety and the need to overcome depression and guilt.

Rational Recovery is a self-help program that uses a cognitive and behavioral approach to achieve recovery from AOD abuse and addictive behavior. These groups teach and utilize the techniques of rational-emotive therapy. Although there are very few women-only Rational Recovery groups, AOD-abusing women may benefit from the emphasis on group process and self-reliance. While the groups are considered self-help, they include the participation of an advisor or a coordinator. An advisor is a licensed therapist who is aware of community resources and is skilled in crisis intervention. While advisors do not assume counseling or therapeutic roles within Rational Recovery group meetings, they help demonstrate such techniques such as rational-emotive therapy strategies.

In general, women should be encouraged to learn about and utilize the variety of women-only 12-step meetings, mixed-gender 12-step meetings, and alternative self-help models to establish a long-term program of recovery that best fits their needs. These groups will grow commensurately with the growth in women's programming initiatives. As with other treatment components, the individual patient's needs should be considered in making the recommendation for participation in women-only versus mixed-gender self-help groups. Given that self-help meetings can be organized around a variety of special treatment characteristics (gender, dual-diagnosis status, sexual orientation, and career orientation), participation can be tailored to best meet individual patient's concerns.

Other Peer-Support Programs

Compared with drug-free partners or peers, women with AOD disorders, perhaps especially those with children, often have fewer opportunities for healthy social support and may lack support from family or significant others. Thus, peer support program opportunities should be an integral part of IOT programs.

An IOT program can provide the opportunity for an informal peer support network within the context of a structured setting. For example, IOT programs can organize or support women patients and/or alumni to organize a wide range of social activities. These activities may include didactic presentations by local experts on such topics as single parenting, nutrition, and recovery. Activities may be educational and recreational, such as field trips to museums, planetariums, and art galleries, or they may be exclusively recreational, such as excursions to go bowling, dancing, and swimming. Activities may be practical in nature, such as regular trips to the supermarket and other stores.

Ideally, such activities will provide an opportunity for women in early recovery to meet and mingle with women who are in a later stage of recovery (such as recovering alumni). In this way, female patients can learn from and model the behaviors of other women in recovery and become exposed to women in long-term recovery. Also, by creating or sponsoring a substantial pool of recovering alumni, it becomes easy for recovering women to establish close relationships with drug-free friends.

Living Skills

Ideally, IOT programs should provide training in basic living skills when the targeted treatment group is deficient in these areas. Training should include such topics as nutrition, child care, literacy, GED instruction, vocational training, and other topics that have a self-help orientation. Such training can help establish knowledge and skills that are critical for the long-term maintenance of recovery gains. The "clubhouse" model -- in which women work together and teach one another -- can be utilized for this training. Such models are widely used in psychiatric day treatment programs and utilize the skills and experiences of patients to teach and model behaviors for newer program participants.

Addiction During Pregnancy

Pregnant women should not be denied AOD treatment or have treatment postponed because of pregnancy. In fact, since the health and well-being of both the mother and the fetus are at stake, efforts should be made to give pregnant women priority access to AOD treatment services.

Indeed, such priority status is now a requirement for all programs receiving Substance Abuse Block Grant funds from the Center for Substance Abuse Treatment. Programs serving an injecting drug use population must give preferential treatment in the following order: 1) pregnant injecting drug users; 2) pregnant substance abusers; 3) injecting drug users; and 4) all others. These are contained in the *Interim Final Rules, Substance Abuse Prevention and Treatment Block Grants, Department of Health and Human Services, 45 CFR Part 96*.

The rules state that if a program receiving funds from the block grant does not have the capacity to provide treatment services to a pregnant woman who requests treatment, she must be referred to the State AOD agency, which administers the block grant, which is required to refer the woman to a treatment program that can admit her no later than 48 hours after seeking treatment.

A full range of support services may be needed by pregnant women with AOD disorders. In particular, this group may have an even greater need for medical and child care services, compared with other treatment patients.

AOD treatment must be modified in several areas to best serve pregnant women. For example, some medications that are commonly used in outpatient settings are contraindicated for pregnant women. If pharmacotherapy is to be used, the IOT provider must identify which medications can be safely administered during pregnancy. For example, commonly used pharmacological blocking agents such as disulfiram and naltrexone should not be used during pregnancy.

IOT providers should also consider that some pregnant AOD abusers may not be well suited for initial management in the IOT level of care but may require initial stabilization within a medical or residential setting. This high-risk group can be difficult to manage exclusively in IOT settings, especially during early stages of AOD treatment.

Some pregnant AOD-abusing women may not be able or may not choose to stop using AODs while in IOT programs. For other women, being pregnant increases their motivation to become or remain drug-free. Indeed, some women report that they are able to diminish or discontinue their drug use only during pregnancy or as a result of having children. In these instances, efforts should be made to engage them in treatment, to assist them in receiving an appropriate level of care, and to support their involvement with other prenatal support resources. Pregnancy is a valuable opportunity for interventions related to AOD abuse and other medical problems and prevention efforts. Many models of treatment have been established that demonstrate the importance and value of linkages between AOD treatment professionals and other health care providers and specialists.

Special Considerations in Providing IOT to Women

- Advocacy for women's services
 - Psychiatric care
 - Child care
 - Abuse issues
 - Flexible program hours
 - Emotional issues (e.g., shame, anger)
 - Safe houses or transitional living
 - Family issues
 - Transportation
 - Self-help and peer support
 - Meals
 - Living skills
 - Medical care
 - Addiction during pregnancy.
-

Once they achieve the goal of delivering a drug-free baby, women who were motivated to stop AOD use because of their pregnancy are susceptible to relapse within the 6-week postpartum period. Postpartum mothers working with social and child protective services to maintain or regain custody of their children may be amenable to IOT. Overall, the complex issues of pregnant AOD-using women are new to IOT treatment programs.

Minority Ethnic and Cultural Groups

IOT program staff should strive to increase their awareness and sensitivity to the diverse cultures represented in their treatment population and community at large. The attractiveness of IOT programs can be improved through staffing patterns that reflect the cultural diversity of the population being treated. This, along with enhanced program designs that are sensitive to the subtle cultural nuances among different groups, will go a long way to remove barriers to treatment. Enhanced program designs should include cultural competency in content, the delivery of services, and philosophy. In order for a cultural competency goal and/or approach to be successful, it must be supported on all program levels, from administrative to clinical. Meeting program goals that relate to cultural competency may require changes in program mission and philosophy as well as staff enhancement.

Enrollment Issues

Advocacy

IOT programs should support a general openness to differences in background among patients and staff. Further, this receptivity to differences should be openly and actively communicated to both potential patients and referral sources in the surrounding community. Outreach efforts should reflect the cultural competence of the program. IOT programs that target specific ethnic

and cultural groups should actively promote and encourage community involvement. An example of neighborhood community involvement is the establishment of advisory boards. IOT programs should utilize community resources and community networking, including churches, families, and employers.

Patient Assessment

IOT program staff should be sensitive to issues of cultural bias with regard to assessment procedures where both standardized instruments and program-based tools are used. To ensure appropriate test interpretation, instruments should be selected for which norms are available for the ethnic or cultural groups that are being treated.

Program Location

Whenever possible, IOT programs should be located in the community that they are intended to serve.

Treatment Issues

Staffing

Programs should aggressively recruit staff who share a similar background with the patients being treated. Some IOT programs target specific ethnic and cultural groups and are successful in hiring clinical staff with the same background. However, in areas where these ethnic and cultural groups constitute a small percentage of the population, hiring qualified counselors from the same backgrounds may be difficult. Therefore, IOT programs should establish and maintain referral and consultation linkages with mental health and medical professionals from the relevant ethnic and cultural groups.

When available, it is sometimes preferable to match clients and counselors on the basis of shared background characteristics. However, other factors such as gender, comorbid psychiatric disorders, and sexual orientation may also influence the counselor assignment. While staff retain the final decision regarding counselor assignment, client preferences should be considered in making this match. Clearly, matching clients to the clinician who is most competent to meet their needs is always the primary consideration.

Regardless of client-counselor matching availability, all IOT staff -- and particularly counselors -- should receive specialized multicultural training in order to be more responsive to the needs of patients from minority cultural and ethnic backgrounds.

Programming

To the extent that it is economically and practically feasible, IOT programs should provide groups on specific ethnic and cultural identity issues so that these treatment issues can be addressed competently within a particular cultural group. As with women's specific programming, such tracks may include a weekly issues group, a regular coordinated group series,

or a separate facility geared specifically to address the treatment needs of a particular ethnic or cultural group. Irrespective of the ethnic and cultural issues being addressed, the overall focus should be on recovery and sobriety.

A program may be best able to consistently incorporate the norms and values derived from the group's ethnic and cultural heritage into program content. Similarly, the special language needs of different groups may be best met through specialized programming. The availability of bilingual counselors must be assured when treating patients who speak another language. The treatment programs that have been developed in recent years for Native Americans represent an outstanding example of the enhanced effectiveness that culturally competent programs can achieve.

In some larger urban areas, AOD abusers have the option of choosing culturally specific IOT programs. At a minimum, IOT programs can hold weekly groups of special interest, which patients can elect to attend. In conducting such groups, it is important to keep the content focused on the recovery issues of the clients and to maintain a problem-solving orientation.

However, such groups can extend beyond problem solving and support to a therapy orientation. This can be achieved by guiding the patient through the therapy process starting with the issues the patient deems to be of most immediate and primary importance to AOD recovery, and later broadening the scope to include more group and community-oriented issues.

Whatever form treatment takes, it is essential that culturally competent IOT services incorporate the concept of equal and nondiscriminatory services and include the concept of culturally responsive services matched to the patient group.

Treatment Planning and Goal Setting

Treatment planning and goal setting should be sensitive to the individual patient's recovery goals in establishing expectations, planning content, and incorporating values.

Family

As discussed more fully above in the overview of this chapter, IOT programs should adopt a flexible definition of family, and accept the family system as it is defined by the patient and influenced by ethnic, cultural, and regional factors.

Other Modalities

Expressive, creative, and nonverbal interventions characteristic of a specific cultural group can prove to be helpful in treatment. For example, in one predominantly African-American AOD program, a choir has been developed; members have chosen to emphasize traditional spiritual music.

Spiritual issues are often central to clients from some cultural groups. They should be recognized and perhaps incorporated into programs. In programs for Native Americans, for example, the

integration of spiritual norms, customs, and rituals enhance the relevance and acceptability of services.

Program Administration

Program Policy

Program policy should explicitly endorse and respect the cultural diversity of program patients, staff, and the community. This should be reflected in the development and enhancement of the program philosophy and mission statement, in program outreach activities, in staffing, and in the tailoring of patient services.

Program Assessment

Mechanisms should exist for programs to initiate ongoing self-assessments regarding services for minority ethnic and cultural groups. The purpose of self-assessments is to establish program goals and objectives in a manner that reflects the cultural competency and concerns of the IOT program. One particularly effective method of program assessment is to survey patients at the time of discharge. Surveys of community members may help clarify the accessibility and sensitivity of the program. For example, programs with governing or advisory boards should recruit representative members that reflect the cultural diversity of the community and who will have a role in the program assessment process.

Special Considerations for Providing Culturally Competent IOT

- Advocacy for special services
- Unbiased assessment tools
- Convenient program location
- Staff with backgrounds similar to clients'
- Staff training in multicultural issues
- Specialized programming (including bilingual counselors)
- Sensitivity to spiritual issues
- Program assessment of special services.

Patients With Dual Disorders

Patients who have a psychiatric and an AOD disorder can be described as having dual disorders. A higher prevalence of psychiatric disorders is evident among people with AOD disorders compared with the general population. People with combined psychiatric and AOD disorders have special treatment needs, requiring adjustments in treatment programming to adequately treat them. An extensive discussion of the special treatment needs of patients with dual disorders is available in a companion CSAT *TIP -- Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*.

Treatment Systems

Patients whose psychiatric disorders are not severe can be treated effectively in an IOT program as long as they receive additional treatment services and medication for their psychiatric disorder as required. Since the treatment needs of people with dual disorders are often complex and require an intense level of services, a more intensive treatment placement should be considered. Specialized psychiatric treatment can be provided in IOT programs by staff or consulting psychiatrists, psychologists, and other qualified clinicians.

As an alternative, IOT programs can establish an active relationship with existing providers of mental health services. When so established, there should be close coordination and strong linkages between the two (or more) programs and providers. These linkages can be fostered through the efforts of a case manager or a multidisciplinary team process involving staff from both programs.

If the single integrated program design is utilized, specialized group sessions for patients with dual disorders are often useful to help them accept the idea that while their recovery may not be as rapid and smooth as that of uncomplicated patients, it is still possible. These patients can be taught about the expected course of their progress in treatment and recovery and can learn how to identify problems before they become clinically significant. Also, education regarding medication maintenance may be particularly helpful. Patients must be strongly cautioned about the dangers of using AODs in combination with their prescribed psychotropic medication, and the need to continue pharmacotherapy during their recovery. Patient education groups that provide education about the purpose and function of psychotropic medication can help clarify common misunderstandings about the use of medications by recovering patients, increase medication compliance, and help patients participate more actively in their treatment. Such groups can help prepare a patient to educate recovering peers about his or her need for prescribed medication.

Patients With Nonchronic Symptoms

One practical way to classify AOD patients that have psychiatric symptoms is with regard to changes in their symptoms following cessation of AOD use. Among most AOD patients who experience psychiatric symptoms, when the symptoms are AOD related, the symptoms diminish and fade following AOD cessation. However, for a subset of patients, psychiatric symptom intensity remains stable or increases. It is this subset of patients who are described as having dual disorders and who require additional treatment for their psychiatric disorders.

Spontaneous Resolution

Symptoms of depression and anxiety will diminish or cease following cessation of AOD use for some patients, and after the resolution of withdrawal symptoms for others. For such patients, the use of psychotropic medication is unnecessary beyond the medical management of withdrawal. These patients can be successfully mainstreamed into the IOT program.

Persistent Symptoms

Coexisting mood and anxiety disorders are the most common reasons for the persistence of psychiatric symptoms. These symptoms usually respond to medication, psychotherapy, and other treatments such as biofeedback and aerobic exercise. Antidepressant medication can be used by AOD patients in the same manner as it is used by nonaddicted patients. However, benzodiazepines should be avoided because of their abuse and addiction potential among people with a history of AOD problems.

If a mood disorder persists and remains untreated, the patient has an elevated risk of relapsing or dropping out of the AOD treatment program. Clinicians disagree somewhat about the optimal length of time to wait before prescribing medication for a mood disorder; the range is generally from 2 to 8 weeks after cessation of AOD use. However, it is particularly important to determine early in treatment if depressive symptoms predated the AOD disorder or if the depressive symptoms persisted during previous periods of abstinence. If either of these is true, IOT staff may want to initiate early pharmacologic intervention for current depressive symptoms. For these patients, assessment followed by reassessment within 2 to 3 weeks is critical.

Symptom Reemergence or Worsening

Clinicians should be alert to the coexistence of AOD disorders and dissociative post-traumatic stress, obsessive-compulsive disorder, or attention-deficit hyperactivity disorder. For these patients, AODs are often used for self-medication.

For example, patients with dissociative disorders may experience the reemergence of traumatic memories and subsequently become psychotic, suicidal, or frightened. Treatment is complicated by the necessity of avoiding benzodiazepine medications that would ordinarily be beneficial. On the other hand, there is evidence that stimulant medications can be safely used by some AOD patients with attention-deficit hyperactivity disorder.

Because their discomfort and increased tendency to relapse can be disruptive to other patients, AOD patients whose psychiatric symptoms worsen following abstinence can often be very difficult to integrate into general IOT programs. Furthermore, the usual program norms and expectations may need to be adjusted in ways that are confusing and unacceptable to other patients. While some patients with dual disorders may be clinically described as high functioning, their behavior may be unpredictable and disruptive to the therapeutic milieu. Thus, they often are better managed apart from other patients, with an emphasis on individual counseling services.

Patients With Chronic Psychotic Disorders

Patients who have an AOD use disorder and a chronic psychotic disorder have treatment needs that exceed those of the average patient with dual disorders. Therefore, they require IOT programs that can provide specialized services to address their needs, including those related to cognitive deficits, physical and social problems, and medication.

The treatment progress of these patients may be slow and prolonged, often compromised by their limited social and interpersonal skills. Also, since these patients may be involved with several treatment and social service systems, they often have numerous program demands placed on them, including attendance requirements and separate treatment goals for each program. The coordination of care and treatment goals is essential if treatment is to be effective. This requires consistent collaboration among clinicians in the various settings in which these patients receive treatment.

This group of patients may benefit from IOT programs that provide an extended treatment day of perhaps 5 to 6 hours. IOT can become a major focal point of their lives and provide structure to an otherwise poorly structured lifestyle.

Like all AOD treatment programs, IOT programs for patients with dual disorders should incorporate a multidisciplinary approach. Staff training regarding psychiatric disorders and the use of medications for these disorders is an important component. As discussed above, it may be necessary for some patients to receive concurrent treatment from multiple programs. When this is the case, it is critical that effective communication and collaboration be established and maintained between providers.

While the length of stay at AOD treatment programs should always be based on the treatment needs and progress of individual patients, some AOD programs promote a fixed amount of time for care. In contrast, IOT programs for patients with an AOD use disorder and a chronic psychotic disorder should always be open-ended. The duration of treatment should be based on each patient's treatment needs. The treatment team should describe clearly the patient's coexisting disorders and explicitly describe treatment goals, progress, and interventions to meet the patient's treatment needs.

Extended care plans should be anticipated and carefully developed. Counseling should be proactive in planning postdischarge placements and services. Despite complex psychiatric treatment needs, abstinence and other AOD treatment goals are expected to be met.

Special Considerations for Providing IOT To Clients With Dual Disorders

- Additional treatment services
 - Linkages with mental health care providers
 - Specialized group sessions
 - Medication education
 - Attention to worsening symptoms
 - Coordination of care for patients with chronic psychotic disorders
 - Staff training in psychiatric disorders.
-

Potential Areas of Conflict

The AOD Field "Versus"

The Mental Health Field

The AOD treatment and the mental health treatment fields emerged from different backgrounds. The two systems of treatment have somewhat different theoretical bases and clinical approaches. For example, abstinence from AODs is considered to be the starting point and an area of continual focus for most AOD treatment programs and models, whereas abstinence may be a later goal and less closely monitored by mental health clinicians. Other differences in orientation and programming are outlined in [Exhibit 5-1](#).

At times, these differences become barriers to integrating and linking AOD and mental health services for patients with dual disorders. For example, there is a potential for conflict regarding the optimal way to handle the failure of a patient to remain abstinent. AOD treatment programs may have a tendency to discharge patients who have episodes of AOD use, whereas mental health programs are more likely to sustain involvement with the patient despite an absence of progress or partial progress with regard to AOD recovery. AOD treatment staff can be commended for a steadfast focus on abstinence. Similarly, mental health staff can be commended for identifying and encouraging patients' progress despite AOD use or in areas that do not appear to be directly related to AOD use.

Further, some AOD professionals may mistakenly regard all psychotropic medication as mood-altering drugs to be avoided because of the potential for abuse. On the other hand, some mental health clinicians may prescribe medications without recognizing that certain psychoactive medications are more likely to be abused than others and that some people are at a higher risk for abuse and addiction than other people. While problems remain, it is fortunate that some conflicts are diminishing in part because of the increased sophistication and integration of both treatment fields. A few recommendations follow.

- AOD treatment and mental health clinicians should become familiar with the perspective, content, and mission of one another's discipline.
- IOT programs should encourage and actively provide clinical cross-training sessions. This can be accomplished through routine clinical supervision, onsite inservice programs, and attendance at regional workshops and national conferences.
- The development of innovative integrated approaches should be encouraged by both fields.

Medication Management

The treatment of patients with dual disorders at an intensive level of care (such as medically monitored inpatient settings) is simplified greatly when the physician prescribing psychotropic medications works on site. When this is so, treatment services can be closely coordinated with all members of the multidisciplinary clinical team. However, at the IOT level of care, some or all of the medical care may be provided by physicians outside of the treatment program. Such physicians include individual patients' primary care physicians, part-time medical directors, and

contract or consulting physicians. In these cases, IOT staff must coordinate treatment services with these outside providers.

Ideally, physicians who provide services for AOD treatment programs should have experience and knowledge about addiction, such as physicians who are addiction medicine specialists or who have addiction medicine as a secondary area of expertise. For example, members of the physician organization American Society of Addiction Medicine are often primary care physicians, internists, or psychiatrists and also have a specialization in addiction medicine. In practice, however, AOD programs, including IOT programs, must often utilize medical and psychiatric personnel who have not developed specializations in addiction medicine. Even without expertise in addiction, such physicians provide valuable services such as physical examinations, withdrawal management, and diagnosis and treatment of psychiatric symptoms and disorders.

However, when programs use such physicians, it becomes possible for the medical and AOD treatment staff to have different treatment goals or different approaches to the same treatment goals. For example, a primary care physician and a psychiatrist who are not addiction medicine specialists may routinely prescribe short-term courses of benzodiazepines for insomnia in their private practices, since they generally obtain good results and witness few adverse reactions among their nonaddicted patients. Unless they are made aware of the explicit clinical goals and objectives of AOD treatment and recovery, medical treatment recommendations may conflict with overall AOD treatment goals.

In situations where there is variability with regard to physician expertise in addiction medicine, and when much of the medical and psychiatric work is done by part-time consultants, programs should provide formal procedures that will result in uniform philosophies and orientations regarding AOD treatment.

Also, while AOD treatment staff should be willing to educate medical and other staff about the goals of AOD treatment, they should be willing to learn about medical management. Importantly, AOD staff must be willing to learn that exceptions to drug-free treatment goals will be appropriate for a subset of dually diagnosed patients. AOD staff should receive ongoing education about medical management including new pharmacotherapies that are prescribed for patients.

Relations With Self-Help Groups

All IOT programs should establish linkages to various self-help groups and to the recovering 12-step community through personal relations with alumni who attend those groups. In particular, IOT programs that provide services for patients with dual disorders should attempt to identify self-help group meetings that welcome and are sensitive to the needs of such patients. In some areas, there are special meetings for people with dual disorders. Such groups have been affectionately called "double trouble" meetings. Patients with dual disorders may need to be taught how to educate their self-help peers about their special treatment needs, especially their need for medication. Patients with dual disorders may benefit strongly by having a sponsor who

has a thorough understanding of recovery for patients who require medical management for psychiatric disorder as well as addiction.

Homeless People

It is incorrect and counterproductive to assume that people who are homeless or who experience housing instability cannot be successfully treated for their AOD disorder until their housing needs are met. Rather, because of the intensity of services available in IOT programs, these programs offer an exceptional opportunity to initiate and maintain an element of stability in homeless people's lives. Such stability may, in turn, enhance the opportunities for addressing housing needs. To accomplish this task, IOT programs should work closely with staff members at homeless shelters and with public housing authorities.

Clinicians should be aware that an individual's resistance to treatment may be related to the length of time he or she has been homeless. For instance, longer periods of homelessness are often associated with stronger resistance to using medical and mental health services. As a result, programs can encourage engagement with the treatment process by helping people get their safety, survival, and social service needs met. This may involve providing assistance regarding housing, food, medical problems, and social services. Programs can provide homeless people with some services on site and assist with access to services off site.

As people begin to have their survival needs met, begin to feel safe, and experience some degree of stability, they become increasingly likely to respond positively to treatment. During the stabilization process, programs can provide informal counseling and reinforcement and other services through case management.

While the emphasis in IOT programs on addiction and recovery issues should not be obscured by housing issues, it should be recognized that homelessness often translates directly into an AOD relapse issue. That is, the ready availability of AODs on the streets and in many homeless shelters, in combination with the stress and poor quality of life that accompany homelessness, often contributes to relapse. For homeless AOD abusers, these issues need to be addressed as a part of effective case management. There is a distinct need to address long-term rehabilitation goals for homeless people. Additionally, since homeless people often experience several medical and psychological problems, a thorough assessment should take such problems into consideration.

The homeless population includes groups of people who can be described as: 1) living in transient situations, 2) recently displaced, and 3) chronically homeless. These three groups arrive at treatment with distinct treatment needs.

Transient People

Some people have transient and unstable living arrangements such as temporarily staying with others. For example, some individuals have a living arrangement pattern that involves rotating among a group of friends, relatives, and acquaintances. These people are at immediate risk of eviction at the will of those with whom they reside. They are at high risk for suddenly having to

live in the street. They are particularly vulnerable to being exploited and abused. For some, continued living in other people's residences may be contingent upon providing sex or drugs. While they may not be living on the streets, they lack a stable, secure, and safe living arrangement.

Recently Displaced People

Some people who experience acute housing instability may have only recently become homeless. They may be employed but have been evicted or otherwise lost their place to live. Sometimes housing instability relates to AOD-influenced financial problems.

As one aspect of providing treatment, IOT programs have a responsibility to help people gain access to temporary housing through such facilities as homeless shelters and halfway houses, or to reestablish a permanent residence. In this way, patients can continue to participate in treatment and remain employed. Effective case management is a critically important way to address these issues.

Chronically Homeless People

Because of the difficulty of attracting chronically homeless AOD abusers into traditional treatment settings, innovative strategies are needed to reach and engage them in treatment. IOT programs cannot expect homeless AOD abusers to negotiate the maze of social services or to identify and secure AOD treatment. Rather, IOT programs must bring their services to the homeless through a variety of creative outreach and programming initiatives. For example, the location of the IOT intervention is of vital importance. One strategy for encouraging homeless people to become engaged with the AOD treatment process is to locate the programs within homeless shelters. Another strategy is to place an AOD treatment specialist at the shelter as a liaison with the IOT program.

For chronically homeless AOD abusers, IOT offers an opportunity for habilitation, which is important for this group since many have not had an opportunity to fully develop basic living and vocational skills. IOT programs must offer linkages to job skills and literacy development services as well as housing. To capitalize on this opportunity, case management must be available to ease access to and coordinate participation in the variety of services needed by homeless AOD abusers.

Medical care, including psychiatric care, should be coordinated for chronically homeless patients. Ideally, it should be integrated with the IOT program's services. This will enable staff to monitor followup care and, as appropriate, medication compliance.

Some shelters will also provide comprehensive case management as well as child care. At a minimum, IOT programs can provide the core elements of IOT in a shelter. However, the location of treatment services is not as important as the coordination of AOD treatment with other medical and social services for homeless people. Thus, IOT programs should establish cooperative programming with homeless shelters and their associated provider networks.

Special Considerations for Providing IOT to Homeless Persons

- Linkages with shelters and public housing authorities
 - Need for food, medical care, and social services
 - Quality case management
 - Long-term rehabilitation goals (job skills, literacy)
 - Innovative strategies to engage chronically homeless (IOT programs in shelters)
-

People With HIV or AIDS

Inadequate access to health care is a major obstacle confronting many AOD abusers with HIV infection or AIDS. Health care facilities in some areas of the country are so overwhelmed that people with HIV or AIDS often cannot gain admittance to clinics that could provide them with the wide range of services needed to sustain or prolong their health.

One of the advantages of the IOT setting is its ability to offer diverse services, particularly when services are incorporated into standard IOT care. Thus, it can provide a greater breadth of care to HIV-positive AOD abusers. Specifically, for patients with HIV or AIDS, IOT programs can provide onsite medical and pharmacologic services as well as access to psychiatric care. These services are essential, since there are significant medical and psychiatric problems in this group - greater problems than those found in the population of people with AOD use disorders.

In IOT, retention of HIV-infected and AIDS patients can be especially challenging without the advantage of residential structure. HIV-infected patients may at times lack motivation to pursue treatment, struggling with a commitment to recovery in the face of perceived imminent sickness and death. Counselors should be prepared to deal directly with this issue and to encourage patients to openly address their ambivalence about recovery. Participation of patients in special support groups dealing with HIV and AIDS should be encouraged when available. To this end, IOT programs should sponsor onsite support groups for people with HIV infection or AIDS. These support groups should address such issues as AOD recovery within the context of AIDS, social isolation, bereavement, fear, and stress.

The HIV/AIDS issue should not be overlooked in IOT and requires special training efforts for IOT staff. Indeed, some AOD treatment certifying bodies require training in this area. There may be a tendency by counselors to refer HIV-related issues to medical providers. However, support, supervision, and training should be available within the IOT setting for all staff members who will encounter such issues. There should be built-in procedures to address the fears, discomforts, and grief resolution associated with working with HIV/AIDS patients. Moreover, it is imperative that the IOT program staff receive training to effectively deal with the issues of death, dying, grief, and bereavement.

Each IOT program will have limitations with regard to the number and types of services provided. At the same time, patients with HIV and AIDS will require more types of treatment and social services than the average patient being treated for AOD problems. For this reason, IOT programs that treat patients with HIV and AIDS have the responsibility to establish and maintain strong linkages to a wide range of services. These linkages must be characterized by ongoing relationships among providers, easy access for patients, and broad scope. They must not simply be passive referrals.

Whether services are provided by the program or through linkages with outside programs, IOT programs should aggressively address a broad scope of issues related to patients' physical, cognitive, psychological, emotional, social, and spiritual health.

Special Considerations for People With HIV and AIDS

- Onsite medical and pharmacologic services
- Access to psychiatric care
- Special support groups onsite
- Support and training for staff
- Strong linkages to a range of services

Gay Men and Lesbian Patients

Gay men and lesbian patients may identify certain issues that make their recovery difficult. IOT programs will be more effective in their treatment of gay men and lesbian patients if they recognize these issues and observe the following guidelines:

- IOT programs should have broad definitions of the family and of relationships. It is important to understand that sexual behavior occurs within a context of other life issues, and that defining people solely on the basis of their sexual orientation is never appropriate.
- IOT program staff need sensitivity training around gay and lesbian issues.
- Having openly gay and lesbian staff in the IOT program may be particularly empowering to gay and lesbian patients as well as educational for heterosexual staff.
- IOT staff should establish an atmosphere in which gay and lesbian patients can feel comfortable. The establishment of this "comfort level" should begin at intake. For example, in obtaining information on sexual orientation, it is important to be nonjudgmental and supportive of whatever information patients provide.
- Gay and lesbian patients should not be compelled or coerced to reveal their sexual orientation to other patients. This is abusive and disrespectful of patients' rights. Further, focusing on sexual orientation is a distraction from the primary focus of treatment for and recovery from addiction to AODs.

However, for some patients, issues related to sexual orientation are central to understanding their patterns of drug use, addiction, recovery, and relapse. For these people, avoiding discussions of sexual orientation may represent a reluctance for self-disclosure relating to addiction in general.

- If patients decline to disclose their sexual orientation to other patients, exploring their reasons for not doing so may be helpful in individual counseling sessions. For example, it may reveal their perception of the program environment as unreceptive to gays.
- The needs of gay men and lesbians also reflect the gender differences that exist among heterosexual men and women. In addition, since the dynamics of gay male and lesbian relationships are different, there may be differences in the way the addicted person's partner responds to addiction, prompting the need for different treatment strategies.
- In larger urban areas, the gay and lesbian communities often have sophisticated support structures, many of which have developed in the context of AIDS advocacy groups. IOT staff should identify these groups, establish linkages, and work closely with these important resources.
- In areas where needed support services are not available, IOT programs should consider establishing support groups for gay men and/or lesbians, depending upon the patients' needs. IOT programs can also sponsor or encourage 12-step group meetings (such as AA) that focus on recovery for gay people.
- Irrespective of sexual orientation, the primary focus of AOD treatment should remain on AOD issues such as sobriety, relapse prevention, and recovery. Regardless of clients' sexual orientation, HIV risk issues should be assertively addressed during treatment. These issues include the high-risk behavior of engaging in sex during episodes of

AOD use, since safer sex is not as consistently practiced when participants are intoxicated or high.

- It is worthwhile to have appropriate literature for gay men and lesbians, especially gay recovery literature and local gay newspapers and magazines where available. It is helpful to have literature on homophobia and homosexuality available for education of heterosexual staff and patients.

Special Considerations for Gay Men And Lesbians

- Broad definition of family
 - Special staff training
 - Gay and lesbian staff
 - Respect for clients' privacy
 - Close linkages with community support groups
 - Address HIV risk issues
-

Elderly Patients

Overall, elderly people constitute a small portion of patients receiving AOD treatment, especially IOT treatment. In defining special treatment needs based on age, a cutoff of 55 has generally been adopted. When establishing guidelines for older patients, programs should consider special groups where elderly patients can deal with issues specific to their life circumstances. These groups can help prevent isolation, promote social interaction, and enhance a feeling of togetherness. To ensure effective treatment, the following key issues also need to be addressed.

Stigmatization

Elderly people, perhaps especially from minority cultural and ethnic groups, often have stereotypical ideas about AOD abuse and feel especially stigmatized when they have AOD problems. As a group, they tend to be reluctant to seek out AOD treatment. They may require especially sensitive approaches to engage them in treatment.

Setting and Transportation

Ideally, a special setting such as a Veterans Administration Hospital or senior center works best for IOT programs exclusively treating elderly people. Such settings afford an increased mix of older people, enabling elderly patients to more readily identify with the treatment group. While program content may not be particularly different in IOT programs that include elderly people, a safe location is vital.

Transportation can be an issue with elderly people as well, particularly for evening programs. If patients cannot provide their own transportation, family members, public transportation, or senior citizen transportation services should be explored.

Cognitive Issues

Cognitive impairment is a more common problem among elderly patients than among others in the IOT program. Some elderly patients may be confused, particularly early in treatment while still recovering from AOD withdrawal. They may be especially demanding of staff time and require attention for their fears and anxieties. The logistics of handling this group can be demanding. Because of cognitive problems secondary to alcohol use, withdrawal, or resulting from the interaction of prescribed medications with alcohol, a subset of these patients may first require medically monitored or managed inpatient treatment. This will provide a more protected environment for patient care and will facilitate closer patient monitoring by program medical staff.

As part of the assessment process, it is important for IOT staff to distinguish between chronic physiologically based impairment and acute impairment related to AOD use. A comprehensive medical history, physical examination, and AOD history are necessary to help clarify patients' needs.

Medication

Medication is a critical issue for elderly people with AOD problems. Physiologic changes in the elderly affect AOD metabolism and tolerance. Also, alcohol can interact with prescribed medications and lead to confusion or toxicity. Elderly patients are more susceptible than other patients to the effects of consuming multiple medications. However, it is common for elderly patients to take multiple medications for several illnesses.

Similarly, elderly patients often receive treatment and medication from several physicians and specialists. Often, this care is not coordinated or supervised by a single treatment provider. Without coordination and supervision, the risk for prescription medication toxicity is heightened. Similarly, when prescription of psychoactive medications is not monitored, the risk of physical dependence and addiction increases.

Cognitive impairment resulting from poor medication management or the interaction between alcohol and prescribed medication can affect the ability of elderly people to take part in IOT. Thus, medication monitoring and management should occur directly within the IOT program whenever possible.

Social Support

Social support is particularly critical for elderly people. In cases of late-onset AOD abuse, the abuse is often related to a recent traumatic life event such as the loss of a spouse or other loved one, or retirement from long-term employment. Since IOT provides a structure for daily living and offers intensive levels of support, it may be of particular benefit to older patients who have experienced a traumatic event.

Depending on local resources, there are often several community support services with which IOT programs can establish linkages. Community support services include medical and other health services, education and recreation activities, and services for daily living. Health services include medical day care centers and clinics that provide health screenings. Services for daily living include homemaker and home health aide services. Other services include senior day care centers, meal delivery services, phone call-in or visiting services, and transportation services. Linkages with churches and senior day care centers can provide patients with a wide variety of activities.

Other Services

Peer helpers for elderly patients can be beneficial. As with other patients, when elderly AOD abusers are accepted by their peers, the progress of their treatment proceeds more rapidly and smoothly. AA groups targeted for older patients represent a partial solution to help meet this need. Exercise, such as weightlifting, stretching, aerobics, or certain martial arts, should be an integral element of the program. Moreover, providing meals helps people meet their nutritional needs and also provides an opportunity to socialize.

Special Considerations for Elderly Persons

- Stigmatization of AOD problems
 - Setting (convenient, safe)
 - Transportation
 - Cognitive impairment
 - Medication interactions (polypharmacy)
 - Close linkages with social services
 - Peer helpers
 - Provide meals onsite
-

People in the Criminal Justice System

The Center for Substance Abuse Treatment is preparing several Treatment Improvement Protocols relating to criminal justice issues. These include *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*; *Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System*; *Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System*; and *Integrating Alcohol and Other Drug Abuse Treatment With Alternative Case Processing in the Justice System*.

Many people in the criminal justice system have AOD use disorders and require treatment. Intensive outpatient treatment can be adapted to various criminal justice settings and can be used to target a number of criminal justice populations, including: 1) incarcerated people, 2) people receiving alternative sentences, and 3) people on parole and probation. These groups often differ in their treatment needs.

Location of the IOT Program

For incarcerated patients, the IOT program is located within the corrections facility, with program staff having reasonably ready access to patients. The corrections facility may have a dormitory arrangement where IOT patients live apart from the general prison population.

Program Rules and Regulations

There is a high prevalence of antisocial personality disorder among AOD patients in the criminal justice system. Thus, behavioral management strategies may be particularly useful for treating incarcerated AOD abusers.

Clarification and enforcement of IOT unit rules and regulations are particularly critical. Through a team effort involving treatment and correctional staff, well-detailed program policies and procedures should be developed before the program becomes operational. Program policy and procedures must clearly reflect the requirements and restrictions of the correctional setting. For example, disclosure of a patient's threat to facility security is not prevented by program

confidentiality guidelines. There are other confidentiality guidelines regarding criminal justice system clients. These guidelines should be communicated to clients.

Treatment Modeling

IOT programs in the criminal justice system can be organized using a day treatment model of care. Also, the duration and scheduling of care can be tailored to patients' length of stay in prison and anticipated release date. Indeed, successful IOT completion can be made a prerelease condition.

In some States, patients on parole will come to IOT directly from AOD treatment units within Federal or State correctional facilities. For these patients, IOT will be perceived as a form of continuing care. Regular participation in an IOT program might be a requisite of their parole; this can promote their retention in the program. Participation of the criminal justice professional in supervising this stage of treatment can be helpful in applying appropriate leverage when patients become unmotivated or unwilling to commit to the treatment plan.

Likewise, it is important that patients not be inappropriately considered in violation when experiencing setbacks in treatment. Communication and coordination between IOT program staff and the relevant criminal justice professionals are important elements in the successful treatment of criminal justice system clients.

Transitional Issues

For clients in the criminal justice system, making the transition back to society (to community, family, and peers) can be extremely challenging. Since they face a twofold integration, people who have been participating in an IOT program with only their incarcerated peers may experience a difficult reintegration with the broader recovery community. For this reason, linking the patient with aftercare AOD treatment services as well as community-based prisoner support services can be beneficial.

Special Considerations for the Criminal Justice Client

- Location in corrections facility
 - Clarification and enforcement of rules
 - Day treatment model
 - Making AOD treatment a release or parole/probation condition
 - Close communication between program staff and criminal justice staff
-

Patients From Other Special Groups

There are a number of other patients for whom specialized IOT tracks can be developed. For instance, people in certain occupations (such as health care professionals, airline pilots, lawyers, and long-distance truck drivers) are special groups that, in large urban centers, already have IOT programs specifically tailored to their singular needs. These programs are often designed so that participants can continue to pursue their occupations while receiving treatment. These groups are often highly motivated to abstain from AOD use because of oversight by their licensing organizations. People with disabilities or cognitive impairments or who are illiterate also require special administrative and clinical considerations. IOT program policies should address the special needs of such clients.

Although there may be concern that such patients may see themselves as "different" or less troubled than the general population, it is generally useful to support involvement in homogeneous support groups while facilitating concurrent interaction with other AOD patients. Other special groups may be identifiable in certain regions and communities. IOT programs are encouraged to consider the special patient groups in their area and evaluate the usefulness of targeted services.

Summary

IOT is becoming an increasingly important level of care for the treatment of AOD problems. This level of care can be adapted to several models and programs that treat patients from special groups. There are several practical and philosophical issues that need to be considered prior to developing IOT services that treat specific groups. Such considerations include the treatment goals and mission of specialized services, counselor sensitivity toward special groups, access to training regarding special population needs, aggressive integration with other services for the target population, patient volume, and financial support.

When these considerations do not support the development of a separate specialized IOT program, enhancement of more general IOT services with special groups and tracks should still be considered. Only by organizing clinical services to be more responsive to the special needs of patients they treat will IOT programs be able to attract, retain, and have an impact on the diversity of patients who are in need of treatment.

Making Treatment Comfortable

- Nonjudgmental staff
- Attention to patients rights
- Staff reflective of the general population
- Encouragement of patients respecting one another
- Literature and art that demonstrates respect for different cultures
- Promotion of emphasis on AOD treatment
- Attention to barriers to treatment and recovery

- Literature to educate staff and patients about each cultural and ethnic group
- Self-help groups for patients from special groups
- Attention to patients' special needs

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Chapter 6 -- Special Fiscal and Administrative Issues

Effective fiscal and administrative management helps provide a solid foundation for the delivery of clinical services. Alcohol and other drug (AOD) treatment programs often face shrinking budgets and cutbacks -- despite intense demands for improvements regarding the qualification of clinicians, quantifiable treatment outcomes, and the quality of service delivery. This has been a time of profound change with regard to health care delivery services -- for both providers and payers in private and public spheres. More change is on the horizon, such as national health care reform. While such reform seems inevitable, the specifics are yet to be determined, and the effect on AOD treatment delivery is as yet unknown. For these reasons, a few aspects of program administration warrant a brief discussion in this TIP:

- Quality improvement
- Public funding
- Private funding
- Managed care
- Program costs.

Quality Improvement

Many people in AOD programs are familiar with the terms *quality assessment and quality improvement* in relation to meeting Federal and State regulations, or meeting the standards for accreditation by such organizations as the Joint Commission on Accreditation of Healthcare Organizations. In the past, the responsibility and perceived responsibility for quality assessment and improvement within an AOD treatment program was assigned to an individual who was designated as the "QA person." While it is true that program administration and clinical administration have the ultimate authority to establish policy and modify procedures regarding quality improvement, all program personnel -- clinical and nonclinical -- are responsible for quality improvement efforts at all program levels.

Indeed, the emphasis on the importance of all employees being an integral part of quality improvement is part of a sound management approach that puts significant emphasis on meeting the needs of the customer or client as an essential aspect of improving the quality of service delivery. One such management approach is called Total Quality Management (TQM). Although TQM origins are in the private business sector, it is becoming an integral component of private and public health services delivery systems. For example, the Joint Commission on Accreditation of Healthcare Organizations, an organization that has as its mission the improvement of the

quality of health care, is making a purposeful shift away from describing these efforts as "quality assessment and improvement," and toward the concept of "improving organizational performance."

By doing so, they are explicitly stressing the continual improvement of health care service delivery by improving the performance of all staff members, prompting enhanced performance of the program, and resulting in improved service delivery (Joint Commission on Accreditation of Healthcare Organizations, 1993).

A Brief Look at TQM

TQM is a focused management philosophy for providing the leadership, training, and motivation to continuously improve an organization's management and operations ([Walton, 1990](#)). The TQM approach includes several strategies and assumptions that are easily adaptable to IOT programs. These strategies include:

- Recognition of quality as the presence of value rather than the mere absence of defect
- Focusing on prevention of problems rather than merely eliminating late-stage problems
- Creation of a working environment where all employees seek continuous improvement
- Emphasizing significant cross-training and teamwork
- Focusing on the services being delivered as well as the process of providing services
- Forging a provider-customer partnership to work on improvements.

There are several key principles that are intrinsic to TQM. These include a focus on the customer, continual process improvement, communication, strategic quality planning, quality leadership, quality skills training, and quality measures. The heart and soul of TQM are the principles of continued focus on the customer and continual improvement of the process involved in providing customer products and services. These key principles can be understood as steps that form the basis of an ongoing cycle of change and improvement. When one phase of the cycle is completed, the cycle begins anew.

- **Customer focus** -- Irrespective of funding or setting, AOD programs provide services to various customers. Thoughtful consideration must be given to the idea of what constitutes a customer for an AOD treatment program. Indeed, it is critical to identify all the customers in the system. While patients are one obvious type of customer, there are others, including referral sources, family members, employers, funding sources, and other providers. Central to the TQM approach is a constant emphasis on satisfying the needs of the customer and identifying ways that can best meet those needs. Importantly, there should be an understanding of the strengths and weaknesses in the system from the customer's perspective, and involvement of the customer in problem solving.
- **Continuous process improvement** -- Service delivery involves products and processes. *Products* are the things that are provided to a client, including treatment services. *Processes* include everything that is done to provide the client with the products and services. Programs that are actively involved with making quality improvements must focus on both products and processes and continual improvements. The emphasis is on improvement, not compliance with existing structures. The goal is to reduce chronic waste of time, labor, material, and funds. Often this

involves the identification and analysis of critical processes and the simplification and removal of variation.

- **Communication** -- The TQM approach recognizes that the individuals who are actually performing certain jobs are the best sources for identifying improvement opportunities for those job functions. Thus, to encourage program-wide participation, all staff, including administrators, must share information and experiences continually. This can be accomplished through newsletters, suggestion boxes, teamwork days, meetings, and other events.
- **Strategic quality planning** -- Critical to TQM is having a vision or mental image of a future state where the quality of service delivery always elicits satisfaction. A goal is a statement of attainable achievement that can be proposed and accomplished with sustained effort and energy over a given length of time. Specific vision statements help program staff to identify the kind of future that is preferred for the program. Setting quality goals helps motivate employees and promotes teamwork. In order to achieve quality goals, programs must be committed and must communicate that commitment to all staff members. An initial step is to formalize the organizational planning process. Quality plans include such elements as mission, goals, measurable objectives, vision, customer identification, quality policies, management principles, benefits, expectations, external and internal measures, role of quality assurance, and productivity initiatives. Through employee committees, documentation, and constant communication, the plan becomes a part of the day-to-day operations and the culture of the organization.
- **Quality leadership** -- Program leaders (both administrators and program staff) have critical roles in the development of quality within their programs. They help provide a focus on the patient. They can support and encourage all staff to participate in quality improvement and install structures, such as task forces and steering committees, and allocate resources. They become role models and nonverbally communicate their commitment to quality by directing their attention to promotion of quality. As previously mentioned, employees who perform certain tasks are often the best sources for identifying improvement opportunities for those tasks. Since such staff members may not have great stature in the formal hierarchy, it is essential that staff members become empowered by administrators and management. In this way, anyone can assume leadership roles within the program.
- **Quality skills training** -- TQM involves a plan for providing training about quality in order for employees to achieve quality goals and objectives. Ultimately, all staff should be trained in the tools and techniques of TQM. Staff training should include such topics as quality principles and concepts, continuous process involvement, problem solving, setting measurable objectives (benchmarking), working in teams, managing in a participative environment, evaluating outcomes, and communications.
- **Quality measures** -- In order to identify opportunities for quality improvement, programs must assess where their strengths lie. This can be done through regular assessment processes that check for compliance with Federal or State laws or accreditation requirements. This can also be accomplished through patient feedback, questionnaires, focus groups, and other practices. But the focus of TQM is on the utilization of quality measures. Measures may be utilized throughout an organization to provide feedback on a regular basis regarding the degree to which the program is meeting its quality goals, objectives, and standards. An array of methods may be used to simplify data collection and statistical analysis and develop useful, reliable information that serves as a real-world scorecard. These may include client surveys, benchmarking, statistical process control, work flow analysis, and cost of quality measures.

These measures are not limited to providing care, but can also be applied with regard to such problems as waiting lists. From the perspective of TQM, waiting lists relate to customer satisfaction issues: patient discontent based on the inaccessibility of treatment services. Thus, TQM would approach the subject of waiting lists in an ongoing, revolving cycle of improvement, in this case, continually making improvements that result in shorter waiting lists.

Key Principles of Total Quality Management

- Customer focus
 - Continual process improvement
 - Communication
 - Strategic quality planning
 - Quality leadership
 - Quality skills training
 - Quality measures
-

Quality improvement is an essential aspect of IOT programming. TQM practices can be easily adapted to the IOT program environment and can have a tremendous impact with regard to improving AOD treatment. TQM projects have been used in the IOT setting for such purposes as the following:

- Analyzing treatment planning and continuity of care issues that arise in IOT from the widespread use of outside agencies to address a range of medical, psychiatric, and psychosocial issues of program clients
- Examining defined interdisciplinary problems and issues and establishing problem-solving groups across the different disciplines when integrated services are delivered within the IOT setting.

Permanent Program Mechanisms for Quality Improvement

All IOT programs should adhere to the following quality improvement guidelines.

- Staff should continually look for opportunities for improvement within the service delivery area, focusing on defining the breadth of customers served by the program. While the patient is the most obvious customer, staff should consider referral sources, funding sources, ancillary care providers, employers, and family members as customers to whom services are provided.
- IOT staff should measure the effectiveness of the IOT program based on such program variables as the length of client retention, the level of patient participation, and the frequency and patterns of attendance. Also, they should monitor patient information, including discharge status and program completion, patient relapse, and return to treatment.

For some evening IOT programs, involvement in quality improvement efforts can be challenging regarding the issue of using part-time contract staff as group therapists. Such staff may be

present in the program only during hours when full-time, permanent staff are not available, creating potential communication problems between the two groups. One strategy for involving part-time staff in the quality improvement process is to have them cofacilitate therapy groups with a member of the full-time core staff and/or establish a regular channel for communication and feedback, such as regularly scheduled meetings, phone calls, or written communication logs.

- Programs should conduct customer surveys to obtain direct feedback on program strengths and weaknesses and recommendations for improvement from clients, referral sources, family members, funding sources, and other programs.
- Programs should gather data to help State programs accurately determine what variables will help predict whether an AOD abuser will stay in IOT care or will progress therapeutically. For example, programs can compare baseline assessments of clients who complete treatment with the assessments of clients who do not complete treatment.
- In IOT outcome evaluations, it is important to include all program participants, including those who have dropped out of treatment. Also, in a State system, which has many types of treatment programs, cross-program comparisons can be made when it is impossible to make random assignment.
- The examination of administrative issues should not be avoided when IOT practices are evaluated. There should be adequate resources allocated to administrative needs, including continuous quality improvement.

Outcome Measures

Evaluation of program outcome is a very effective way of obtaining the information needed to improve some aspects of the quality of the program. IOT programs can incorporate outcome evaluations in relation to ongoing clinical work and patient improvement. IOT programs must establish and clarify program goals and objectives in order to conduct an outcome analysis, and to know the meaningful outcome indicators.

Moreover, outcome data should be used not only to determine whether the IOT program is doing a "good" or "bad" job, but also to interpret the nuances. For instance, when looking at AOD use among clients, a complete picture of the overall program impact on the client is needed, including general psychosocial and quality-of-life indicators. A considerable amount of data can be examined without sophisticated statistical analysis. For instance, IOT programs should be able to examine program attendance and patient outcome data and be able to readily apply findings to the program evaluation processes. An appropriate management information system should be implemented to ensure rapid and complete access to outcome data.

A variety of outcome measures are needed, including staff and administrative measures, special population measures, general treatment population measures, and treatment services.

Staff and administrative measures. Staff and administrative measures clarify outcomes by holding staff responsible for particular program components and by making them active participants in the ongoing processes of the program. Using program evaluations, staff turnover rates should be examined in different IOT programs as a measure of the level of staff satisfaction. However, when making a decision regarding program philosophy, caution should be

used regarding how the staffing satisfaction data are used. Occasionally, program changes that foster superior client care can precipitate initial discomfort and resistance among program staff.

Special population measures. It is important to emphasize that program and patient outcome indicators will be different for different treatment groups. For instance, clients with dual disorders may have a different threshold for attendance than AOD patients without dual disorders. Additional outcomes that are meaningful with this group include medication compliance, psychiatric symptom improvement, and rehospitalization. Similarly, special outcome indicators may be appropriate for pregnant IOT clients including delivery complications and birth outcomes for infants.

General treatment population measures. A useful outcome measurement tool is the Addiction Severity Index (ASI) ([McLellan et al., 1980](#); [1985](#); [1992a](#)). The ASI can be administered at IOT intake and discharge by trained assessment staff members. Used at intake, it leads logically to treatment planning. At discharge, it yields specific outcome data in seven key areas of the client's life, including recent AOD use and legal, occupational, medical, family/social, and psychiatric status.

The ASI provides IOT programs with:

- A subjective patient evaluation and an interviewer evaluation of problem severity, both of which can provide an indication of patient treatment priorities.
- An easy monitoring tool for clinical supervision since severity scores in each domain can be quickly checked to ensure adequate treatment planning in problem areas.
- The capability to monitor outcomes of discharged clients through community followup. (Patients can be located and reevaluated using the ASI followup interview.)
- A research tool structured to derive objective and subjective measures of need and improvement.
- A rich database by which such issues as the relationship between client characteristics and outcome data can be examined.
- A standardized assessment instrument that permits comparisons across programs and levels of care.

Treatment Services Review. The Treatment Services Review was developed to complement the ASI and corresponds directly to ASI categories ([McLellan et al., 1992](#)). This instrument provides a structured way of measuring patient perception of the quantity of services received in each of the seven ASI areas. That is, it yields a perceived services-delivered rating. Other important measures of patient-level service delivery include: number of individual counseling sessions, number of group counseling sessions, number of urine tests and Breathalyzer checks, and length of stay.

Other measures. IOT programs also should conduct client satisfaction surveys as an evaluation tool. Self-help group involvement is another way of measuring continued sobriety and determination to retain or regain any short-term loss of sobriety.

One measure of particular relevance to the IOT setting is the successful transfer and retention of clients in long-term standard outpatient services following completion of the IOT program.

Patient follow-through with the transition plan should be automatic. A primary goal of IOT services should be to motivate clients to remain in ongoing recovery programs.

External Evaluation Processes

A number of institutionalized review processes provide useful feedback for IOT programs, including:

- **Accreditation organizations** -- Often, State accreditation processes, such as licensing or certification divisions, as well as national accreditation bodies, such as the Joint Commission on Accreditation of Healthcare Organizations, or the Commission on Accreditation of Rehabilitation Facilities, provide a readily available, and often mandated, source of quality improvement.
- **Consultants** -- IOT administrators may find it helpful to seek professional assistance in defining and clarifying their program mission. Consultants can be particularly helpful with respect to program development, preparing mission statements, stating program philosophies, and translating all of these into procedural policy. Consultants can not only help programs establish and plan TQM programs, they can also "sell" the importance of the TQM process to staff members by conducting staff presentations on TQM.
- **Governing board** -- Whether by choice or because of State regulations, many IOT programs have advisory and/or governing bodies that oversee the development and operations of the program. Members of such governing bodies should have familiarity with AOD treatment and should have ample time to be actively involved. Governing board members should see their role as working in a complementary relationship with the program staff with the common goal of overall success of the program.

A clear mission statement helps make the program direction explicit and realistic. It also helps decrease the tendency of programs to overextend themselves by offering services or treating client populations that are outside their intended mission.

Therapeutic Setting

The appearance of the facility sends a powerful message to IOT clients about dignity and respect. The appearance of the facility can have an impact on patients' assessment of program quality. IOT programs should consider the following recommendations:

- Plan ahead for flexibility regarding treatment team and group space. Maximize the flexibility of available space. When designing a new facility, first evolve an understanding of space needs in order to custom-design the space for most efficient use.
- Keep furniture and facility resources in good working order. The physical surroundings should be clean and tidy.
- Design a space for clients to get away from the therapy rooms during breaks in treatment. Clients need a physical break from the intensive sessions. Space itself can be therapeutic.
- Many IOT programs will want to provide refreshments, and a dining room or cafeteria area is ideal. At the least, a snack machine and coffee should be available.
- For some treatment groups, particularly large urban programs serving a homeless population, shower and laundry facilities will make the IOT program more attractive.

- Certain literature and didactic information should be available. Updated self-help meeting schedules should be present in high-traffic areas such as the clinic lobby.
- Bathrooms should be conveniently located near group therapy rooms and recreational space. Also, the bathrooms should be designed with the need for collection of urine samples for drug screening in mind. Alternatives include one-way mirrors, space for direct observation, and the ability to temporarily turn off the water supply.
- Whenever possible, IOT programs -- especially those with extended hours -- should have a recreation room for patients. These areas should be designed to promote client socialization.
- Each IOT program has to thoughtfully address its smoking policy. This is both a facility and a program philosophy issue. If smoking is allowed internally, make sure the rights of nonsmokers are protected.
- A centralized entrance for client registration may be useful, depending on the particular client groups and setting. This has the added benefit of monitoring who is coming in and out of the program.
- The neighborhood setting is important. While programs should be located in the areas where the target patients reside, the program also should be in a safe location, and be secure. Patients and staff should feel safe participating in treatment, especially in evening programs. Consideration should be given to the level of acceptance that the neighborhood has for the program. Efforts should be made to ensure as cooperative and supportive arrangements as possible.

Public Funding

For most States, the amounts of fiscal support from general revenue and Federal block grants have been inadequate to finance the level of services demanded by the public. Major grant funds, for example, have been used to provide treatment to high-risk youth, women and children, and intravenous drug users. Fortunately, block grant requirements do not restrict the eligibility of any particular types or models of programs. Hence, AOD treatment programs that are based on the intensive outpatient treatment (IOT) level of care are eligible for block grant funds.

Since the States have a fair amount of discretion about the use of block grant funds, they often seek programs that will make effective use of existing monies. One such strategy is to identify specific groups for which State money can be targeted and for which IOT programs can be created. For example, IOT programs may be created to treat such specific groups as intravenous drug users, adolescents, clients with dual disorders, incarcerated offenders, and women and their infants and children. Targeting services to these groups may also help States meet certain Federal block grant requirements, such as the current requirements to give treatment preference to pregnant drug users.

Unfortunately, however, when IOT programs are designed to provide care for narrowly targeted groups, their ability to provide care for the general population of addicted people may be restricted. This means they will be unable to treat many people who require the type of treatment provided by IOT programs. Thus, program planners need to balance these concerns, utilize creative strategies, and identify strategies and additional sources of funding that will permit the broadening of services.

Alternative sources of public funding are available to establish and maintain IOT programs. These sources include funds allocated by Federal or State programs in criminal justice, AIDS, maternal and child health, and mental health and demonstration and set-aside funds from the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP). For example, CSAT, CSAP, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse have supported demonstration projects targeting several specific groups, such as the homeless, pregnant women, and women of childbearing age. These projects, awarded competitively, offer excellent opportunities for innovative programming with an emphasis on a comprehensive continuum of services.

The amount of State funds available to support AOD abuse treatment programs varies widely among the States. Program managers and staff should aggressively seek out and identify potential sources of State funds, and improve the skills required to write and submit grant applications. IOT programs are in especially good positions to develop creative alliances with other treatment providers and submit joint grant applications when permissible.

At this time, Medicaid is an important funding source for providing AOD treatment based in IOT programs. IOT program administrators should be fully informed about State regulations governing the use of Medicaid funds. Some States, for example, may attempt to ensure equitable distribution by granting programs specific amounts of Medicaid and State-match funds. Some programs may not use their full allocation, and the balance can be used by other programs that need more funds. This requires administrators to have a full understanding of the State's procedures and regulations for Medicaid granting and matching. In some cases, where experience has shown that certain programs are able to attract more Medicaid clients than others, the State will arrange for them to bill beyond the amount of their individual grant, as long as the State's pool of Medicaid funds is not exhausted.

In some situations, Medicaid will pay half the cost for treating individuals under age 17. A major problem with Medicaid is that many States do not provide Medicaid coverage for males who are not chronically ill or elderly. At intake it is important to ask men if they have custody of children. If they do, they are probably eligible for Medicaid coverage themselves.

Another creative alternative is a partnership between health maintenance organizations (HMOs) and managed care businesses to provide IOT coverage. A special program can be developed so that patients served by these plans can receive targeted treatment services that conform to their benefits.

In some instances, counties have developed their own managed care programs or even created their own IOT programs -- such as adolescent IOT programs -- which are funded entirely with county taxes. Programs may be able to draw on local, county, or township taxes. This approach saves the jurisdiction from having to pay out-of-county treatment providers for inpatient care. Similarly, some very large employers have developed their own IOT programs for AOD problems among employees.

In many cases, IOT services can be added to existing residential treatment programs. However, there is a risk that allocating funds for an IOT level of care may actually diminish the available

funds for the residential treatment program. Sometimes, when the inpatient facility is reimbursed on a fee-for-service basis, the outpatient programs may be misused as a feeder to the inpatient program.

However, IOT can be combined with residential care in the same program to maximize the opportunity for patient-placement matching, enhance the continuum of care, and reduce the overall cost of AOD treatment services. Some clients require a period of residential stabilization before they can successfully take part in IOT. If admitted directly to IOT, they may relapse. The duration of residential care needed can vary greatly from patient to patient, and must be tailored to individual patients' rates of improvement. However, the goal should be to transition clients to the least restrictive level of care as soon as possible.

The development of State regulations defining and governing IOT programs is a critical step in the recognition and reimbursement of individual programs. As States develop a licensure or regulatory category for this level of care, IOT programs can more easily receive reimbursement.

Private Funding

Benefit structures are underdeveloped in relation to the reimbursement of IOT by private payers. While reimbursement strategies have been developed for inpatient AOD abuse treatment, many third-party payers have not developed any or adequate reimbursement strategies for the IOT level of care.

It is critical for programs that provide or intend to provide IOT services to establish an ongoing dialogue with major payers. Indeed, this dialogue should begin prior to opening an IOT program. This will diminish or possibly eliminate surprises and problems related to reimbursement and clinical issues.

Specifically, third-party payers should be given the opportunity to provide input into the development of reimbursement strategies and should be invited to join with the program as partners in providing quality intensive outpatient treatment.

To enhance cooperation with payers, IOT program providers should pursue and obtain the accreditation, licensing, and certifications that the payers recommend or require. Certifications cannot usually be obtained before a program is operational. These may include Joint Commission on Accreditation of Healthcare Organizations, Commission on Accreditation of Rehabilitation Facilities, and State accreditation.

Suggestions for Providers

- Providers should create and maintain a database related to services that the various payers will reimburse. This database should include: payers (insurer's name, phone number, address, contact people) and information regarding deductibles, copayments, daily rates, capitation (maximum payments), and billing procedures. A tracking mechanism should be included to specify recertification requirements when they exist.

- Providers should meet in person with the reviewers and decisionmakers who approve admissions. By so doing, the provider and payer can have a clear understanding of each other's expectations, practices, and policies. For example, there should be a clear understanding regarding what constitutes a treatment day and how nontreatment days are to be considered.
- Providers should obtain written copies of payers' policies and guidelines for billing and payment, and not rely solely on phone conversations.
- In situations where payers will not furnish providers with written policies and procedures, the provider should send a confirming followup letter or fax memorandum that summarizes the content of a conversation or phone call. Written documentation of informal understandings and agreements can save much money, time, and frustration.
- Payers are increasingly requiring outcome data for reimbursable treatment services. Thus, providers should collect outcome data, so that they can demonstrate quality treatment and quality improvement. Often such data can be gathered at little or no cost by using graduate students or trained support staff to collect followup client information.
- Providers should inform payers that research suggests that for some patients, IOT provides a level of care equivalent to inpatient treatment. This is not true for nonintensive outpatient treatment ([Fink et al., 1985](#)). Therefore, careful patient-treatment matching is needed to ensure that clients are placed in the least restrictive and most cost-effective type of treatment program, based on the severity of their presenting AOD use problem, medical and psychiatric status, and psychosocial conditions. Providers should provide payers with admission criteria that distinguish IOT patients from patients that can be served by lower intensity outpatient services. Further, IOT programs should ensure that the level of care offered is clearly distinct from that available in nonintensive outpatient programs?
- Providers should inform payers that IOT has an important place in continuing care, since the longer clients remain in outpatient treatment, the higher is the likelihood of a more stable recovery ([McCaul and Svikis, 1991](#)).
- When communicating with payers, providers should clearly and carefully describe the specific types, intensity, range, and levels of IOT services that are provided to help payers make informed and educated decisions.
- Providers should establish assertive, close, and ongoing linkages to social service organizations and health care programs that offer other types and levels of care with the greatest cost effectiveness, if services are not provided inhouse.
- During the intake phase of IOT treatment, it is useful to identify whether the client may have additional reimbursement coverage through a spouse's or other family member's insurance policy. Sometimes, despite a client's own exhausted benefits, coverage may be obtained through a secondary payer.

Some payers may regard IOT as an add-on or optional service. It is the responsibility of IOT treatment providers to educate payers that IOT is a specific level of care that can provide a level of treatment intensity that approaches medically monitored inpatient treatment but is achieved in an outpatient setting. Importantly, payers should understand that IOT is a vital part of the continuum of care that includes: 1) medically managed inpatient treatment, 2) medically monitored inpatient treatment, 3) intensive outpatient treatment, and 4) outpatient treatment. Payers should also be educated that IOT is a level of care, not a specific type or model of program. For example, payers should be taught that IOT can be adapted to several models such as day treatment, evening treatment, weekend treatment, partial hospitalization, and treatment in combination with housing such as apartments, dormitories, or other forms of resident housing.

Providers and payers should understand that moving clients from one level of care to a less intense level of care (such as from inpatient care to IOT) will utilize the continuum of care, decrease daily treatment costs, and make it possible to provide prolonged episodes of treatment. However, it is imperative for providers to remind payers that the decisions to move clients from one level of care to another should always be based on the individual client's treatment needs.

In some cases, where payers do not yet have a policy regarding insurance policy conversion from inpatient to outpatient treatment, they may not be able to guarantee this service. However, individual insurance company staff may be able to informally provide such a conversion. In any case, informed agreements should be in writing to avoid misunderstandings that may occur later. There is an increased likelihood for such flexibility when effective, proactive, and ongoing communication and collaboration exists between providers and payers.

There is a need for IOT programs to collaborate with one another in lobbying efforts. Organized National, State, and local institutions can help educate legislators, as well as payers, regarding the benefits of IOT and demonstrate their support for particular payer reimbursement strategies. Professionals from employee assistance programs can work with benefits departments to explain the utility of IOT programs

Managed Care

It is clear that the process of reforming America's health care delivery system is under way. However, it is less clear what the final health care reform package will look like. Also, it is unknown how the new system will affect AOD treatment, mental health services, and Medicaid. In fact, once negotiations are complete and new laws have been established, it is likely that new health care reform policies will be phased in over several years. It is likely that several years will pass before the ultimate effects on AOD treatment and mental health are thoroughly understood. Understandably, and often because of poor experiences with some managed care companies, AOD treatment program administrators are apprehensive about the potential negative effects of a national health care system that incorporates managed care and managed competition.

In existing managed care programs, problems may arise regarding the patient's right to confidentiality in seeking AOD treatment. In managed care settings, patients typically seek initial help from an employee assistance program professional or their managed care provider physician or case worker who then makes the appropriate recommendations and referrals. However, managed care provider physician records are not protected under the Federal confidentiality regulations governing AOD treatment programs. Thus, managed care provider physician records are subject to more liberal disclosure. As a consequence, patient information is not strictly protected in the same way as records in AOD treatment programs.

Clients may not want the managed care provider to reveal to anyone else that they have an AOD abuse problem. Authorization for AOD treatment would require clients to disclose their AOD status to their managed care provider. This is an issue that some States are beginning to address and regulate.

Under managed care models, a capitated agreement -- or at-risk contract -- may be an integral component of providing care. This capitated agreement involves the payment of a monthly or annual flat fee to a treatment provider who agrees to provide a specified range of services to all clients covered by the contract who seek treatment. In effect, to be ensured of regular payments, the provider accepts the risk for delivery of services. In such agreements, the provider should be particularly careful to determine utilization rate histories for the particular geographic areas being served. These rates vary greatly and can have a dramatic impact on costs. For example, utilization rates can range from one to six patients per 1,000 population seeking treatment -- a sixfold range!

Providers that choose to become involved with capitated agreements should request and obtain a utilization rate history. In other words, the provider should have an understanding of the number of people or the percentage of the program's base group that are expected to seek care each year. Similarly, the provider should carefully consider the implications associated with taking the risk for all AOD treatment needs -- which may include detoxification, and inpatient and outpatient treatment -- compared with a capitated agreement that requires only the delivery of IOT and outpatient treatment.

Although the cost of managing care for IOT is less expensive to develop and operate than the cost for many other conditions, it is not inexpensive. Indeed, comprehensive AOD treatment involves attending to medical, psychiatric, and AOD problems that require sophisticated clinical interventions. These interventions require the use of licensed, credentialed, and certified professionals.

Program Costs

Very little data exist on IOT program costs. Although less expensive to operate than inpatient treatment, good IOT programs are not generally inexpensive. Also, they have more difficulty than inpatient programs in generating significant profit margins even when efficiently organized and managed.

The consensus panel obtained data on total expenses and total revenues from six different day or evening IOT treatment programs, in the northeast, Midwest, and southern part of the Nation in rural, urban, and suburban areas. The programs have various payer mixes, including insurance, managed care, Medicaid, Medicare, HMO contract, State grant or purchase of care, and self-pay. Also represented were private nonprofit and for-profit programs as well as a public program, with a variety of client capacities and salary ranges. These data are provided in [Exhibit 6-1](#).

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Chapter 7 -- Legal Issues for IOT Programs¹

Clinical and other personnel who work in intensive outpatient treatment (IOT) programs should be aware of legal and ethical issues that affect their operations. Primary among these issues are several in the area of confidentiality or protection of the client's right to privacy.

For example, an IOT program that assesses and treats patients may need to seek information from other (collateral) sources, such as employers, criminal justice agencies, schools, relatives (including parents), and medical personnel. How can programs approach these sources and at the same time protect the client's right to privacy? How can the program and the many diverse agencies concerned with or responsible for the patient's welfare communicate with each other without violating the confidentiality rules? Can a program communicate with an employer who has referred a client to treatment?

Are there special rules about sharing information with criminal justice agencies? Can a program contact a parent of a minor client without the minor's consent? If the patient is threatening harm to him- or herself or another, can the program call the authorities? How can programs handle clients who show up intoxicated or impaired and insist on driving? Can programs call on the police if a client becomes violent? Can programs report suspected child abuse or neglect?

This chapter attempts to answer these questions.

- The first subsection provides an overview of the Federal laws and regulations protecting the right to privacy of any patient seeking or receiving AOD services.
- The second offers a detailed discussion of the rules governing the use of consent forms to get a patient's permission to release information.
- The third reviews the rules for communicating with others about a client, including how agencies can communicate with each other and how programs can warn others of a client's threat to harm.
- The fourth discusses other exceptions that permit programs to disclose information.
- The final subsection adds a few points about the client's right to confidential services and the need for programs to use legal assistance.

Federal Confidentiality Laws

Two Federal laws and a set of regulations guarantee the strict confidentiality of information about all persons receiving alcohol and other drug (AOD) abuse prevention and treatment

services. The legal citation for these laws and regulations is 42 U.S.C. §§290dd-3 and ee-3 and 42 C.F.R. Part 2. (For a discussion of the rules governing release of HIV/AIDS-related information, see the CSAT TIP *Screening for Infectious Diseases Among Substance Abusers*.)

These laws and regulations are designed to protect clients' privacy rights in order to engage people in treatment. The regulations restrict these communications more than those in many situations, such as the doctor-patient or the attorney-client privilege. Violating the regulations is punishable by a fine of up to \$500 for a first offense or up to \$5,000 for each subsequent offense (§2.4). (Citations in the form "§2..." refer to specific sections of 42 C.F.R. Part 2.)

While some may view the restrictions that the Federal regulations place on communications with others as an irritation or a barrier to their program goals, most of the nettlesome problems that arise under the regulations can easily be avoided through foresight. Familiarity with the regulations will facilitate communication and reduce the conflicts among program, patient, and outside agency to a few relatively rare situations.

Programs Governed by the Regulations

Any program that specializes, in whole or in part, in providing treatment, counseling and/or assessment, and referral services for patients with AOD problems must comply with the Federal confidentiality regulations (§2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid such as tax-exempt status, or State or local government funding coming (in whole or in part) from the Federal government.

Coverage under the Federal regulations does not depend on how a program characterizes its services. Calling itself a "prevention program" does not insulate a program from following the confidentiality rules. It is the kind of services, not the label, that determines whether the program must comply with the Federal law.

The General Rule

The Federal confidentiality laws and regulations protect any information about a client if the client has applied for or received any AOD-related services -- including assessment, diagnosis, counseling, group counseling, treatment or referral for treatment -- from a covered program. Only clients who have "applied for or received" services from a program are protected. If a client has not yet been evaluated or counseled by a program and has not him- or herself sought help from the program, the program is free to discuss the client's drug or alcohol problems with others. But, from the time the client applies for services or the program first conducts an evaluation or begins counseling, the Federal regulations govern patient information.

The restrictions on disclosure apply to any information that would identify the patient as an AOD abuser, either directly or by implication. The general rule applies from the time the patient makes an appointment. It also applies to clients who are civilly or involuntarily committed, clients who are mandated into treatment by the criminal justice system, and former clients. The rule applies whether or not the person making an inquiry already has the information, has other ways of

getting it, enjoys official status, is authorized by State law, or comes armed with a subpoena or search warrant. (For an explanation regarding the response to persons with subpoenas and search and arrest warrants, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1991 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.)

Sharing Confidential Information

Information that is protected by the Federal confidentiality regulations may always be disclosed after the patient has signed a proper consent form. (As explained below, if the patient is a minor, parental consent must also be obtained in some States.) The regulations also permit disclosure without the patient's consent in several situations, including reporting medical emergencies or child abuse and certain communications among program staff.

The most commonly used exception to the general rule prohibiting disclosures is for a program to obtain the client's consent. The regulations' requirements regarding consent are somewhat unusual and strict and must be carefully followed.

Consent

Most disclosures are permissible if a patient has signed a valid consent form that has not expired or been revoked (§2.31). However, no information that is obtained from a program (even if the patient consents) may be used in a criminal investigation or prosecution of a patient unless a court order has been issued under the special circumstances set forth in §2.65 (42 U.S.C. §§290dd-3(c), ee-3(c); 42 C.F.R. §2.12(a),(d)).

A proper consent form must be in writing and must contain each of the items contained in §2.31:

- The name or general description of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the patient
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the patient may revoke the consent at any time, except to the extent that the program has already acted in reliance on it
- The date, event, or condition upon which the consent expires if not previously revoked
- The signature of the client (and, in some states, his or her parent)
- The date on which the consent is signed (§2.31(a)).

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. ([See Exhibit 7-1.](#))

The Purpose of the Disclosure

The purpose of the disclosure and how much and what kind of information will be disclosed are closely related issues. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose of the

disclosure (§2.13(a)). It would be improper to disclose everything in a patient's file if the recipient of the information only needs one specific piece of information.

In completing a consent form, it is important to determine the purpose or need for the communication of information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the need or purpose.

As an illustration, if a patient needs to have the fact that he or she is in treatment verified in order to be eligible for a benefit program, the purpose of the disclosure would be "to verify treatment status" and the amount and kind of information to be disclosed would be "enrollment in treatment." The disclosure would then be limited to a statement that "Susan Jones is receiving counseling at XYZ Program."

The Patient's Right to Revoke Consent

The patient may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, the program has acted in reliance on the consent and is not required to try to retrieve the information.

The regulations state that "acting in reliance" includes providing services in reliance on a consent form permitting disclosures to a third-party payer. Thus, a program can bill the third-party payer for past services to the patient even after consent has been revoked. However, a program that continues to provide services after a patient has revoked a consent authorizing disclosure to a third-party payer does so at its own financial peril.

Expiration of Consent

The form must also contain a date, event, or condition on which the consent will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a)(9)). If the purpose of the disclosure can be expected to be accomplished in 5 or 10 days, it is better to fill in that amount of time rather than a longer period or to have all consent forms uniformly expire in 60 or 90 days.

The consent form does not need to contain a specific expiration date, but may instead specify an event or condition. For example, if a patient has been placed on probation at work on the condition that he or she attend the program, a consent form should be used that does not expire until the completion of the period of probation. Alternatively, if a patient is being referred by the program to a specialist for a single appointment, the consent form should provide that it will expire after he or she has seen "Dr. X."

Signature by Minors and Parental Consent

A minor must always sign the consent form in order for a program to release information -- even to his or her parent or guardian. The program must obtain the parent's signature only if the

program was required by State law to obtain parental permission before providing treatment to the minor (§2.14). The term "parent" includes parent, guardian, or other person legally responsible for the minor.

In other words, if State law does not require the program to get parental consent in order to provide services to a minor, then parental consent is not required to make disclosures (§2.14(b)). If State law requires parental consent to provide services to minors, then parental consent is required to make any disclosures. The program must always obtain the minor's consent for disclosures and cannot rely on the parent's signature alone.

There is one very limited exception to this rule, which is discussed below in "Disclosure to Parents About Minors."

Required Notice Against Redisclosure

Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with written patient consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient cannot further disclose it unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient at the time of disclosure or earlier. ([See Exhibit 7-2.](#))

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from re-releasing information except as permitted by the regulations. (Of course, a patient may sign a consent form authorizing a redisclosure.)

The Use of Consent Forms

The fact that a patient has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b); 2.61(a)(b)). The only obligation the program has is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid (§2.31(c)).

In most cases, the decision whether or not to make a disclosure pursuant to a consent form is within the discretion of the program unless State law requires or prohibits disclosure once consent is given. In general, it is best to follow this rule: disclose only what is necessary, for only as long as is necessary, in light of the purpose of the communication.

Communication With Others

Given these rules regarding consent, consider the questions introduced at the beginning of this chapter:

- How can programs seek information about clients from collateral and referral sources?

- How can the program and the many diverse agencies concerned with or responsible for the client's welfare communicate with each other without violating the confidentiality rules?
- Are there special rules about sharing information with criminal justice agencies?
- Can a program contact a parent of a minor patient without the minor's consent?
- Do programs have a duty to warn others of threats by patients, and if so, how do they communicate the warning? Consider the following examples:
 - - -If the client is threatening harm to him- or herself or another, can the program call law enforcement authorities?
 - -How can programs handle patients who show up intoxicated or impaired and insist on driving?
 - -Can programs call on the police if a patient becomes violent?
- Can programs report child abuse?

Seeking Information from Collateral and Referral Sources

Making inquiries of employers, criminal justice agencies, schools, parents, doctors and other health care entities might seem at first glance to pose no risk to a patient's right to confidentiality, particularly if the person or entity approached for information referred the patient to treatment. But it does.

When a program that screens, assesses, or treats a patient asks an employer, doctor, school, or parent to verify information it has obtained from the patient, it is making a patient-identifying disclosure that the patient has sought its services. In other words, when program staff seek information from other sources, they are letting the sources know that the patient has asked for AOD services. The Federal regulations generally prohibit this kind of disclosure unless the patient consents.

How then is a program to proceed? The easiest way is to get the client's consent to contact the employer, school, health care facility, and so forth.

As noted above, when filling out the consent form, thought should be given to the "purpose of the disclosure" and "how much and what kind of information will be disclosed." For example, if a program is assessing a client for treatment and seeks records from a mental health provider, the purpose of the disclosure would be "to obtain mental health treatment records to complete the assessment." The "kind of information disclosed" would then be limited to a statement that "Katherine Sampson (the patient) is being assessed by the XYZ Program." No other information about Katherine Sampson would be released to the mental health provider.

If the program seeks not only records, but seeks to discuss with the mental health provider the treatment it provided the patient, the purpose of the disclosure would be "to discuss mental health treatment provided to Katherine Sampson by the mental health program." If the program merely seeks information, the kind of information disclosed would, as in the example above, be limited to a statement that "Katherine Sampson is being assessed by the XYZ Program." However, if the program needs to disclose information it gained in its assessment of Katherine Sampson to the mental health provider in order to further the discussion, the kind of information disclosed would be "assessment information about Katherine Sampson."

A program that routinely seeks collateral information from many sources could consider asking the patient to sign a consent form that permits it to make a disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or the name of the organization" for each collateral source the program may contact.

It is important to keep in mind that even when information is disclosed over the telephone, the person disclosing it is still required to notify the recipient of the information of the prohibition on redisclosure. Mention should be made of this restriction during the conversation. For example, program staff could say, "I'll be sending you a written statement that the information I gave you about Ms. Sampson cannot be redisclosed."

Communications Among Agencies

IOT programs often need to be able to communicate on an ongoing basis with the referral source or with other agencies offering services to clients, such as mental health agencies or child welfare officials.

Again, the best way to proceed is to get the patient's consent. Care should be taken in wording the consent form to permit the kinds of communications necessary. For example, if the program needs ongoing communications with a mental health provider, the "purpose of the disclosure" would be "coordination of care for Sharon Dove" and "how much and what kind of information will be disclosed" might be "treatment status, treatment issues, and progress in treatment." If the program is treating a patient who is on probation at work and whose continued employment is contingent on treatment, the "purpose of disclosure" might be "to assist the patient to comply with employer's mandates" or to "supply periodic reports about treatment" and "how much and what kind of information will be disclosed" might be "progress in treatment." Note that the kinds of information that will be disclosed in the two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if that would assist in coordinating care. Disclosure to an employer would most likely be limited to a brief statement about the patient's progress in treatment. Disclosure of clinical information to an employer would, in most circumstances, be inappropriate.

When a client enters treatment voluntarily and not as a result of a referral from an employer, program staff should maintain an open mind about whether communications with an employer would be beneficial to the client. A client who tells program staff that his or her employers will not be sympathetic about the decision to enter treatment may well have an accurate picture of the employer's attitude. Insistence by program staff on communicating with the employer may cost a client his or her job. If such communication takes place without the client's consent, the program may find itself facing an unpleasant lawsuit.

The program should also give considerable thought to the expiration date or event the consent form should contain. For coordinating care with a mental health provider, it might be appropriate to have the consent form expire when treatment by either party ends. A consent form permitting disclosures to an employer might expire when the patient's probationary period at work ends.

Disclosure Rules Regarding Mandated Services

There are special rules about disclosing AOD information about patients mandated into treatment by the criminal justice system. Programs assessing and treating clients who are required to participate as part of a criminal justice sanction must follow the confidentiality rules. However, some special rules apply when a patient is in treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of any criminal proceeding, and information is being disclosed to the mandating agency.

A consent form (or court order) is still required before any disclosure can be made about an offender who is mandated into assessment or treatment. However, the rules concerning the length of time that a consent remains valid are different. Also, a "criminal justice system consent" cannot be revoked before its expiration event or date.

Specifically, the regulations require that the following factors be considered in determining how long a criminal justice system consent will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding in which the offender is involved
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur, and
- Anything else the patient, program or criminal justice agency believes is relevant.

These rules allow programs to continue to use a traditional expiration condition for a consent form that was formerly the only one allowed -- "when there is a substantial change in the patient's criminal justice system status." This formulation appears to work well. A substantial change in status occurs whenever the patient moves from one phase of the criminal justice system to the next. For example, if a patient is on probation or parole, there would be a change in criminal justice status when the probation or parole ends, either by successful completion or revocation. Thus, the program could provide an assessment or periodic reports to the probation or parole officer monitoring the client, and could even testify at a revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing.

As for the revocability of the consent (the rules under which the offender can take back his or her consent), the regulations provide that the consent form can state that consent cannot be revoked until a certain specified date or condition occurs. The regulations permit the criminal justice system consent form to be irrevocable so that a patient who has agreed to enter treatment in lieu of prosecution or punishment cannot then prevent the court, probation department, or other agency from monitoring his or her progress. Note that although a criminal justice system consent may be made irrevocable for a specified period of time, its irrevocability must end no later than the final disposition of the criminal proceeding. Thereafter, the patient may freely revoke consent.

Several other considerations relating to criminal justice system referrals are important. First, any information that an eligible criminal justice agency receives from a treatment program can be used by that justice agency only in connection with its official duties with respect to that

particular criminal proceeding. The information may not be used in other proceedings, for other purposes, or with respect to other individuals (§2.34(d)).

Second, whenever possible, it is best to have the judge or referring agency require that a proper criminal justice system consent form be signed by the patient before he or she is referred to the treatment program. If that is not possible, the treatment program should have the client sign a criminal justice system consent form at his or her first appointment. With a proper criminal justice consent form signed, the AOD program can communicate with the referring criminal justice agency even if the patient appears for assessment or treatment only once. This avoids the unfortunate problems that can arise if a patient mandated into assessment or treatment does not sign a proper consent form and leaves before the assessment or treatment has been completed. [Exhibit 7-3](#) is a consent form for the release of confidential information for a criminal justice referral.

If a program fails to have the patient sign a criminal justice system form and the client fails to complete the assessment process or treatment, the program has few options when faced with a request for information from the referring criminal justice agency. The program could attempt to locate the patient and ask him or her to sign a consent form, but that, of course, is unlikely to happen. And there is some question whether a court can issue an order to authorize the program to release information about a referral who has left the program in this type of case. This is because the regulations allow a court to order disclosure of treatment information for the purpose of investigating or prosecuting a patient for a crime only where the crime was "extremely serious," and a parole or probation violation generally will not meet that criterion.

Therefore, unless a consent form is obtained by the judge or criminal justice agency or by the treatment program at the very beginning of the assessment or treatment process, the program may end up in a position where it is prevented from providing any information to the criminal justice agency that referred the patient.

If a patient referred by a criminal justice agency never applies for or receives services from the program, that fact may be communicated to the referring agency without patient consent (§2.13(c)(2)). But once a client even makes an appointment to visit the program, consent or a court order is needed for any disclosures.

Disclosure to Parents About Minors

Although this TIP primarily addresses the treatment of adults in IOT programs, it is nonetheless useful to be aware of the confidentiality regulations that relate to minors. As has been noted above, programs may not communicate with the parents of a minor patient unless they get the minor's written consent.

In getting the minor's consent, the program should discuss with the minor whether the minor and the program want to be able to confer with the minor's mother and/or father a single time or periodically. This decision will affect how the program fills out the consent form.

If the counselor and/or the minor decide that the counselor should confer with the minor's mother or father only once, "the purpose of the disclosure" would be "to obtain information from Mary's parents in order to assist in the screening (or assessment) process" and "how much and what kind of information will be disclosed" would be "Mary's application for services." The expiration date should be the date the counselor thinks screening or assessment will be completed.

If the program and Mary decide they want the program's counselor to freely speak with Mary's parents over a longer period of time, the program would fill out the consent form differently. The purpose of the disclosure would be "to provide periodic reports to Mary's parents" and the kind of information to be disclosed would be "Mary's progress in treatment." The expiration on this kind of open-ended consent form might be set at the date the program and Mary foresee her counseling ending or even "when Mary's participation in the program ends" (although Mary can revoke the consent at any time).

What if Mary refuses to consent? Since the Federal regulations prohibit disclosures without Mary's consent, the program cannot confer with her parents. Indeed, even if it had regular meetings with them, it must refuse to communicate any further information, including whether Mary is attending the program.

One special situation deserves mention. The Federal regulations contain an exception permitting a program director to communicate with a minor's parents in one limited circumstance: If a minor applies for services in a State where parental consent is required to provide services, but the minor refuses to consent to the program's notifying her parents, the regulations permit the program to contact a parent without consent, if two conditions are met:

- The program director believes that the minor, because of extreme youth or medical condition, does not have the capacity to decide rationally whether to consent to the notification; and
- The program director believes the disclosure is necessary to cope with a substantial threat to the life or well-being of the minor or someone else.

If these two conditions do not exist, the program must explain to the minor that while she has the right to refuse to consent to any communication with a parent, the program can provide no services without such communication and parental consent (§2.14(d)). In States where parental consent is not required for treatment, the regulations permit a program to withhold services if the minor will not authorize a disclosure that the program needs in order to obtain financial reimbursement for that minor's treatment. The regulations add a warning, however, that such action might violate a State or local law (§2.14(b)).

Section 2.14(d) applies only to applicants for services. It does not apply to minors who are already patients. Thus, programs cannot contact parents of patients without consent even if they are concerned about the behavior of their children.

Duty to Warn

For most treatment professionals, the issue of reporting a patient's threat to commit a crime is a troubling one. Many professionals feel that they have an ethical, professional, or moral

obligation to prevent a crime when they are in a position to do so, particularly when the potential crime is a serious one. While these issues may not arise often, IOT programs will almost certainly face questions about their "duty to warn" someone of a client's threatened suicide, a patient's threat to harm another, or a patient's insistence on driving while impaired.

There has been a developing trend in the law to require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn a potential victim his patient threatened to kill and then did kill. The court ruled that if a psychologist or other therapist knows that a patient poses a serious risk of violence to a particular person, the psychologist or therapist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

Strictly speaking, the *Tarasoff* ruling applies only in California. Nevertheless, courts in a number of other States have followed *Tarasoff* in finding therapists liable for money damages when they failed to warn someone threatened by a patient. Most of these cases are limited to situations where patients threaten a specific identifiable victim, and they do not generally apply where a patient makes a threat without identifying the intended victim. States that have enacted laws on the subject have similarly limited the duty to warn to such situations.

In a situation where a program thinks it might be faced with a "duty to warn" question, there are always at least two -- and sometimes three -- questions that need to be answered:

- Is there a legal duty to warn in this particular situation under State law?
- Even if there is no State legal requirement that the program must warn an intended victim or the police, does the program feel a moral obligation to warn someone?

The first question can only be answered by an attorney familiar with the law in the State in which the program operates. If the answer to the first question is "no," it is advisable to discuss the second question with a knowledgeable lawyer, too.

- If the answer to questions 1 or 2 is "yes," can the program warn the victim or someone likely to be able to take action without violating the Federal AOD regulations?

The problem is that there is a conflict between the Federal confidentiality requirements and the "duty to warn" imposed by States that have adopted the principles of the *Tarasoff* case. Simply put, the Federal confidentiality law and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require, unless the disclosure can be made by using one of the regulations' narrow exceptions. [Moreover, the Federal AOD regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hasenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.]

There are four ways a program can proceed when a patient makes a threat to harm him- or herself or another:

- The program can go to court and request a court order authorizing the disclosure. The program must take care that the court abides by the requirements of the Federal AOD regulations. (See the discussion of the court order exception below.)
- The program can make a disclosure that does not identify the individual who threatens to commit the crime as a patient. (See the discussion of the exception for non-patient-identifying disclosures below.) This can be accomplished either by making an anonymous report or -- for a program that is part of a larger non-AOD entity -- by making the report in the larger entity's name. For example, a counselor employed by an AOD program that is part of a mental health facility could phone the police or the potential target of an attack, identify herself as "a counselor at the New City Mental Health Clinic" and explain the risk to the potential target. This would convey the vital information without identifying the patient as an AOD abuser. Counselors at freestanding AOD units cannot give the name of the program.
- The program can make a report to medical personnel if the threat presents a medical emergency that poses an immediate threat to the health of any individual and requires immediate medical intervention (§2.51). (See the discussion of the medical emergency exception below.)
- The program can obtain the patient's consent. This may be unlikely, unless the client is suicidal. (Note that the Federal statutes and regulations strictly prohibit any investigation or prosecution of a client based on information obtained from records unless the court order exception used 42 U.S.C. §§290 dd-3(c) and ee-3(c) and 42 C.F.R. §2.12(d)(1)).

If none of these options is practical, what should a program do? It is, after all, confronted with conflicting moral and legal obligations.

If a program believes there is clear and imminent danger to a patient or a particular other person, it is probably wiser to err on the side of making an effective report about the danger, to the authorities or to the threatened individual. This is especially true in States that already follow the *Tarasoff* rule.

While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a program or a counselor who warned about potential violence when the counselor believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the program should at least try to make the warning in a manner that does not identify the individual as an AOD abuser.

"Duty to warn" issues constitute an area in which staff training, as well as a staff review process may be helpful.

Driving While Impaired

It is inevitable in an IOT program that at some point a patient will arrive at the treatment program intoxicated. If the patient is not in condition to participate appropriately in treatment or to drive home, what should the program do?

There are at least two strategies a program can use to prevent a patient impaired by AODs from driving. First, the program can offer the client a ride home or taxi fare for a ride home.

Second, the program can maintain a room where patients can "sleep it off" and urge patients who arrive at the program intoxicated to stay at the program until they are in a condition to drive. If the patient would not otherwise remain at the program for 8 to 10 hours, the program might be wise to alert the patient's family that he or she will be detained. Since the program must have written consent from the client to call the family in this kind of circumstance, it would also be wise to obtain consents from patients to permit calls to family members when the patients are detained, for whatever reasons.

What if the patient refuses either transportation home or a place to rest until the AODs wear off? What if the patient leaves the program intending to drive home? Does the program have a duty to call the police to prevent an accident? Does it risk a lawsuit if it fails to do so?

As mentioned above, this is a question of State law and can only be answered by an attorney familiar with the law in the State where the program operates. The program should consult an attorney to determine what its responsibility is in this area.

In most States, it is unlikely that the program would be liable, particularly if it had made an effort to stop the client from driving, using either the strategies outlined above or some other method. As noted above, in States that follow the *Tarasoff* doctrine, liability has generally been limited to those situations where a patient threatens to harm a specific person. Liability has generally not been imposed in situations where a patient poses a threat to the community in general.

Even if the program would not be liable if one of its patients leaves the program impaired and causes an accident, it may nonetheless feel an obligation to call the police if all other attempts to prevent the client from driving fail. However, caution must be exercised so that it does not unnecessarily violate the patient's confidentiality.

For example, the program can call the police and tell them that a person driving a 1991 red Ford Pinto with a license number "XYZ 123" is driving from the intersection of Maple and Third and heading toward downtown and is not in a condition to drive. The program should ask the police to respond immediately. What the program cannot do is tell the police that the patient has an AOD abuse problem. This means it cannot tell the police 1) that the patient is impaired by AODs or 2) the program's name (because that would tell the police that the client has an AOD abuse problem).

In order to get the patient's license number and a description of his or her car, it may be necessary to detain the patient for a few minutes. However, the program should avoid using force, since the patient could sue the program for battery or false imprisonment.

Discharging an Unstable Patient

Patients at IOT programs may include severely troubled individuals, some of whom may pose a threat to others, disrupt the program, or make little discernible progress. What should the staff of

a program do if they believe that discharging a patient is the most appropriate disposition, but have concerns that, without ties to a program, the patient may deteriorate and pose a serious danger to others -- identifiable or not?

When a program seeks to involuntarily discharge an unstable patient, there are at least three questions that need to be answered:

- Can the program involuntarily discharge a patient -- whether the discharge is for being disruptive, for not making progress, or for nonpayment? This question can only be answered by an attorney familiar with the law of the State in which the program operates. In some States, the answer may vary depending upon the reason for discharge.
- If the program can involuntarily discharge the patient, does it have a duty do something about the patient -- ensuring that he or she gets continuing care by someone else? Again, the answer to this question lies in State law. Some States might hold a program liable for "dumping" a patient who had few resources to fend for him- or herself and suffered harm.
- Does the program have a duty to warn someone about the patient's instability and potential for harming him- or herself or another? Once again, State law governs this "duty to warn" question. However, note that in this instance, the program is no longer faced with an imminent threat of "serious danger of violence to another." The program is concerned about a patient who has the potential of deteriorating further and becoming a serious danger to another. It therefore seems unlikely that a program would be held responsible for discharging a patient who became more unstable and harmed someone unless there was good reason to believe that he or she would rapidly deteriorate and become a danger to a particular person.

For example, if there were a previous incident in which the patient harmed a particular person when he or she was discharged or left another treatment program, and the patient appears to be a continuing threat to that person, the program would be well advised to warn the person (or someone likely to apprise the person) that the patient is about to be discharged. Of course, it is best to do so without violating the Federal regulations.

Reporting Patients' Criminal Activity

What should a program do when a patient tells a staff member that she intends to outfit her children in new clothes by shoplifting -- a crime the counselor knows she has committed many times? Does the program have a duty to tell the police? And does a program have a responsibility to call the police when a client discloses to a counselor that he has participated in a serious crime -- some time in the past?

These are two very different questions that require separate analyses, although they have similar answers.

A program generally does not have a duty to warn another person or the police about a patient's intent to commit a crime unless the patient presents a serious danger of violence to an identifiable individual. Shoplifting rarely involves violence, and it is unlikely that the counselor will know which stores are to be victimized. Petty crime like shoplifting is an important issue that should be dealt with therapeutically. It is not something a program should report to the police.

Suppose, however, that a patient admits during a counseling session that he killed someone during a robbery 3 months ago. Here the program is not warning anyone of a threat, but serious harm did come to another person. Does the program have a responsibility to report the patient's admission to the police?

When clients disclose to a counselor that they committed a crime some time in the past, there are generally three questions that need to be answered.

- Is there a legal duty to report the past criminal activity to the police under State law?
- Generally, the answer to this question is no. In most States, there is no duty to report a crime committed in the past to the police. Even those States that continue to regard failure to report a crime as a crime itself rarely prosecute violations of the law.
- Does State law permit counselors to report the crime to the police if they want to?

Whether or not there is a legal obligation imposed on citizens to report past crimes to the police, State law may make conversations between counselors of AOD programs and their patients privileged. AOD treatment professionals have a special relationship with their patients. In many States this relationship is protected by laws designed to keep confidences private. Such State law privileges may exempt counselors from any requirement to report past criminal activity by patients and may also prohibit counselors from disclosing a patient's confession even if they want to.

State laws vary widely on the protections they accord communications between clients and counselors. In some States, admissions of past crimes may be considered privileged and counselors may be prohibited from reporting them. In other States, admissions may not be privileged. Moreover, each State defines the kinds of relationships protected differently. Whether a communication about past criminal activity is privileged (and therefore cannot be reported) may depend upon the type of professional the counselor is and whether he or she is licensed or certified by the State.

Any program that is especially concerned about this issue should ask a local attorney for an opinion letter about whether there is a duty to report and whether any counselor-patient privilege either exempts counselors from that duty or prohibits voluntary reporting.

- If State law requires a report (or permits one and the program decides to make a report), how can it comply with the Federal confidentiality regulations and State law?

Any program that decides to make a report to law enforcement authorities about a patient's prior criminal activity must do so without violating the Federal confidentiality regulations. A program that decides to report a patient's crime can comply with the Federal regulations by following one of the first two methods above in the discussion about duty to warn. It should obtain a court order or make the report in a way that does not identify the individual as an AOD patient.

Because of the complicated nature of this issue, any program considering reporting a patient's admission of criminal activity should seek the advice of a lawyer familiar with local and Federal laws.

Crimes on Premises or Against Personnel

When a client has committed or threatens to commit a crime on program premises or against program personnel, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient in the program (§2.12(c)(5)).

Reporting Child Abuse And Neglect

All 50 States have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral report and many now have toll-free numbers to facilitate reporting. (Half the States require that both oral and written reports be made.) All States extend immunity from prosecution to persons reporting child abuse and neglect. Most States provide for penalties for failure to report.

Because of the variation in State laws, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance. Many State statutes require that staff report instances of abuse to administrators, who are then required to make an official report. Thus, programs concerned about this issue should establish reporting protocols to bring suspected child abuse to the attention of program administrators, who in turn should shoulder the responsibility to make the mandated reports.

The Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. However, this exception to the general rule prohibiting disclosure of any information about a patient applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information or even subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the patient consents or the appropriate court issues a special court order (see below).

More Exceptions to the General Rule

Reference has been made to other exceptions the Federal confidentiality rules make to the general rule prohibiting disclosure. In the pages that follow, six additional kinds of exceptions are explained:

- Information that does not reveal the patient is an AOD user
- Disclosures authorized by a special court order
- Information disclosed in a medical emergency
- Information shared with staff within the program

- Information disclosed to an outside agency that provides the program with services
- Information disclosed to researchers, auditors, and evaluators.

A number of these exceptions have been mentioned above. A brief explanation of each follows.

Communications Not Disclosing Patient-Identifying Information

The Federal regulations permit programs to disclose information about a patient if the program reveals no patient-identifying information. "Patient-identifying" information is information that identifies someone as an AOD abuser. Thus, a program may disclose information about a patient if that information does not identify the patient as an AOD abuser or verify anyone else's identification of the patient as an AOD abuser.

There are two basic ways a program may make a disclosure that does not identify a patient. The first way is obvious: a program can report aggregate data about its population (summing up information that gives an overview of the patients served in the program) or some portion of its population. Thus, for example, a program could tell the newspaper that in the last 6 months it had 43 patients, 10 female and 33 male.

The second way is trickier: A program can communicate information about a patient in a way that does not reveal the person's status as an AOD abuse patient (§ 2.12(a)(i)). For example, a program that provides services to patients with other problems or illnesses as well as AOD abuse may disclose information about a particular patient as long as the fact that the patient has an AOD abuse problem is not revealed. An even more specific example: A program that is part of a general hospital could have a counselor call the police about a threat a patient made, so long as the counselor does not disclose that the client has an AOD abuse problem or is a patient of the AOD abuse treatment program.

Programs that provide only AOD treatment services or that provide a full range of services but are identified by the general public as AOD programs cannot disclose information that identifies a patient under this exception, since letting someone know a counselor is calling from the "XYZ IOT Program" will automatically identify the patient as someone who received services from the program. However, a freestanding program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the patient's status as an AOD abuser.

Court-Ordered Disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about a client that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information (§2.61). (For an explanation about how to deal with subpoenas and warrants, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1991 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.)

Before a court can issue an authorizing court order, the program and any patient whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court. [However, if the information is being sought to investigate or prosecute a patient, only the program need be notified (§2.65). And if the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).] Generally, the application and any court order must use fictitious names for any known patient, and all court proceedings in connection with the application must remain confidential unless the patient requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any adverse effect that the disclosure will have on the patient, the doctor-patient relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)). The judge may examine the records before making a decision (§2.64(c)).

If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a client for a crime, the court must also find that 1) the crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury; 2) the records sought are likely to contain information of significance to the investigation or prosecution; 3) there is no other practical way to obtain the information; and 4) the public interest in disclosure outweighs any actual or potential harm to the patient, the doctor-patient relationship, and the ability of the program to provide services to other patients. When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. If the program is a governmental entity, it must be represented by counsel (§2.65(d)).

There are also limits on the scope of disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and disclosure must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the patient's confidentiality, including sealing court records from public scrutiny (§2.64(e)).

The court may order disclosure of "confidential communications" by a client to the program only if the disclosure a) is necessary to protect against a threat to life or of serious bodily injury, or b) is necessary to investigate or prosecute an extremely serious crime (including child abuse), or c) is in connection with a proceeding at which the patient has already presented evidence concerning confidential communications (§2.63).

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual." The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The medical emergency exception permits disclosure only to medical personnel. This means that this exception can not be used as the basis for a disclosure to the police or other nonmedical personnel, including parents.

Under this exception, however, a program could notify a private physician about a suicidal patient so that medical intervention can be arranged, and the physician could, in turn, notify a patient's parents or other relatives, so long as no mention is made of the patient's AOD abuse problem.

Whenever a disclosure is made to cope with a medical emergency, the program must document in the client's records the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.

Qualified Service Organization Agreements

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into what is known as a qualified service organization agreement (QSOA).

A QSOA is a written agreement between a program and a person providing services to the program, in which that person:

- Acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the program, it is fully bound by the Federal confidentiality regulations; and
- Promises that, if necessary, it will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations (§§2.11, 2.12(c)(4)).

A QSOA should only be used when an agency or official outside of the program is providing a service to the program itself. An example is when laboratory analyses or data processing is performed for the program by an outside agency.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. QSOAs may not be used between programs providing AOD treatment services. A sample QSOA is provided in [Exhibit 7-4](#).

Internal Program Communications

The Federal regulations permit some information to be disclosed to individuals within the same program.

- - *The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or*

referral for treatment of alcohol or drug abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (§2.12(c)(3)).

This means that staff who have access to patient records because they work for or administratively direct the program -- including full- or part-time employees and unpaid volunteers -- may consult among themselves or otherwise share information if their substance abuse work so requires.

Other Requirements

Patient Notice and Access to Records

The Federal confidentiality regulations require programs to notify patients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to patients when they begin participating in the program or soon thereafter (§2.22(a)). The regulations also contain a sample notice.

Programs have the discretion to decide when to permit clients to view or obtain copies of their records, unless State law grants the right of access to records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Security of Records

The Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe or other similar container. The program should establish written procedures that regulate access to and use of clients' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§2.16).

A Final Note

AOD treatment programs should identify and retain a lawyer familiar with local laws affecting their programs. As has already been mentioned, State law governs many areas with regard to screening and assessing adolescents. A local practitioner is the best source for advice on such issues. Moreover, in some areas, the law is still developing. For example, programs' duty to warn of patients' threats to harm others is constantly changing as courts in different States consider cases brought against a variety of care providers. Programs trying to decide how to handle such a situation need up-to-the minute advice on their legal responsibilities. It is recommended that IOT staff routinely receive regular legal issues updates as part of their staff development processes.

Research, Audit, or Evaluation

The confidentiality regulations also permit programs to disclose patient-identifying information to researchers, auditors and evaluators without patient consent, providing that certain safeguards described in Sections 2.52 and 2.53 of the Federal regulations are met (§§2.52, 2.53). (For a

more complete explanation of the requirements of §§2.52 and 2.53, see *Confidentiality: A Guide to the Federal Laws and Regulations*, published in 1991 by the Legal Action Center, 153 Waverly Place, New York, NY 10014.)

Endnote

1. This chapter was written for the consensus panel by Margaret K. Brooks, Esq.

Your browser does not support JavaScript

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

[\[Back Matter\]](#)

Appendix A -- References

Alcohol, Drug Abuse, and Mental Health Administration.

The Economic Costs of Alcohol and Drug Abuse and Mental Illness. Washington, D.C.: Alcohol, Drug Abuse, and Mental Health Administration, 1985.

Alfs, D.S., and McClellan, T.A.

A day hospital program for dual diagnosis patients in a VA medical center. *Hospital and Community Psychiatry* 43(3):241-244, 1992.

American Psychiatric Association.

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, D.C.: American Psychiatric Association, 1984.

Beckman, L.J., and Amaro, H.

Personal and social differences faced by women and men entering alcoholism treatment. *Journal of Studies on Alcohol* 47:135-146, 1986.

Bensinger, A., and Pilkington, C.F.

An alternative method in the treatment of alcoholism: the United Technologies Corporation day treatment program. *Journal of Occupational Medicine* 25(4):300-303, 1983.

Blume, S.B.

Women and alcohol: a review. *Journal of the American Medical Association* 256:1467-1470, 1986.

Fink, E.B., Longabaugh, R., McCrady, B.M., Stout, R.L., Beattie, M., Ruggieri-Authelet, A., and McNeil, D.

Effectiveness of alcoholism treatment in partial versus inpatient settings: twenty-four month outcomes. *Addictive Behaviors* 10:235-248, 1985.

Furst, C., Beckman, L., Nakamura, C., and Weiss, M.

Utilization of Alcohol Treatment Services in California. Los Angeles: UCLA Alcohol Research Center Neuropsychiatric Institute, 1981.

Goodwin, D.W.

Inpatient treatment of alcoholism: new life for the Minneapolis plan. *New England Journal of Medicine* 325:804-806, 1991.

Hayashida, M., Alterman, A.I., McLellan, A.T., O'Brien, C.P., Purtill, J.J., Volpicelli, J.R., Raphaelson, A.H., and Hall, C.P.

Comparative effectiveness and costs of inpatient and outpatient detoxification of patients with mild-to-moderate alcohol withdrawal syndrome. *New England Journal of Medicine* 320:358-365, 1989.

Hoffman, N.G., Halikas, J.A., Mee-Lee, D., and Weedman, D.

Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders. Washington, D.C.: The American Society of Addiction Medicine, 1991.

Hoffman, N.G., and Harrison, P.A.

CATOR Report: Perspective on Admission and Outcome. St. Paul, Minnesota: Ramsey Clinic, 1988.

Hoffman, N.G., and Harrison, P.A.

CATOR Report: Treatment Outcome -- Adult Inpatients Two Years Later. St. Paul, Minnesota: Ramsey Clinic, 1988a.

Hoffman, N.G., and Miller, N.S.

Treatment outcomes for abstinence-based programs. *Psychiatric Annals* 22(8):402-405, 1992.

Horn, J.L., and Wanberg, K.W.

Alcoholism symptom patterns of men and women: a comparative study. *Quarterly Journal of Studies on Alcoholism* 31:40-51, 1970.

Hubbard, R.L.

Drug Abuse Treatment: A National Study of Effectiveness. Chapel Hill: University of North Carolina Press, 1989.

Institute of Medicine.

Broadening the Base of Treatment for Alcohol Problems. Washington, D.C.: National Academy Press, 1990.

Institute of Medicine.

Treating Drug Problems: A Study of the Evolution, Effectiveness, and Financing of Public and Private Drug Treatment Services. Washington, D.C.: National Academy Press, 1990.

Joint Commission on Accreditation of Healthcare Organizations.

Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services. Oakbrook Terrace, Illinois: Joint Commission on Accreditation of Healthcare Organizations, 1993.

Kofoed, L., Kania, J., Walsh, T., and Atkinson, R.M.

Outpatient treatment of patients with substance abuse and coexisting psychiatric disorders. *American Journal of Psychiatry* 143(7):867-872, 1986.

Leukefeld, C.G., Pickens, R.W., and Schuster, C.R.

Improving drug abuse treatment: recommendations for research and practice. In: Pickens, R.W., Leukefeld, C.G., and Schuster, C.R., eds. Improving Drug Abuse Treatment. National Institute on Drug Abuse, 1991. pp. 394-406.

Longabaugh, R., McCrady, B., Fink, E., Stout, R., McAuley, T., Doyle, C., and McNeill, D.

Cost effectiveness of alcoholism treatment in partial versus inpatient settings: six-month outcomes. *Journal of Studies on Alcohol* 44:1049-1071, 1983.

McCaul, M.E., and Svikis, D.S.

Improving client compliance in outpatient treatment: counselor-targeted interventions. In: Pickens, R.W., Leukefeld, C.G., and Schuster, C.R., eds. Improving Drug Abuse Treatment. Rockville, Maryland: National Institute on Drug Abuse, 1991. pp. 204-217.

McLellan, A.T., Alterman, A.I., Cacciola, J., Metzger, D., and O'Brien, C.P.

A new measure of substance abuse treatment: initial studies of the Treatment Services Review. *Journal of Nervous and Mental Disease* 180(2):101-110, 1992.

McLellan, A.T., Kushner, H., and Metzger, D.

The fifth edition of the Addiction Severity Index. *Journal of Substance Abuse Treatment* 9(3):199-213, 1992a.

McLellan, A.T., Luborsky, L., Cacciola, J., Griffith J., Evans, F., Barr H.L., and O'Brien, C.P.

New data from the Addiction Severity Index: reliability and validity in three centers. *Journal of Nervous and Mental Disease* 173:412-423, 1985.

McLellan, A.T., O'Brien, C.P., and Woody, G.E.

An improved diagnostic evaluation instrument for substance abuse patients: the Addiction Severity Index. *Journal of Nervous and Mental Disease* 168:26-33, 1980.

Price, R.H., Burke, A.C., D'Aunno, T.A., Klingel, D.M., McCaughrin, W.C., Rafferty, J.A., and Vaughn, T.E.

Outpatient drug abuse treatment services, 1988: results of a national survey. In: Pickens, R.W. Leukefeld C.G., and Schuster, C.R., eds. Improving Drug Abuse Treatment. Rockville, Maryland: National Institute on Drug Abuse, 1991. pp. 63-92.

Reed, B.G.

Developing women-sensitive drug dependence treatment services: why so difficult? *Journal of Psychoactive Drugs* 19:151-164, 1987.

ed.gif" ALT="View the Medline version of this and related citations using NLM's PubMed">

Roman, P.M.

Women and Alcohol Use: A Review of the Research Literature. Rockville, Maryland: Alcohol, Drug Abuse, and Mental Health Administration, 1988.

Scivoletto, S., Guerra de Andrade, AG., and Castel, S.

The effect of a "recall-system" in the treatment of alcoholic patients. *British Journal of Addiction* 87:1185-1188, 1992.

Thom B.

Sex differences in help-seeking for alcohol problems, 1: The barriers to help-seeking. *British Journal of Addiction* 81:777-788, 1986.

Unterberger, G.

Twelve steps for women alcoholics. *Christian Century* December 6:1150-1152, 1989.

Verinis, J.S.

Characteristics of patients who continue with alcohol outpatient treatment. *International Journal of the Addictions* 21(1):25-31, 1986.

Walsh, D.C., Hingson, R.W., Merrigan, D.M., Levenson, S.M., Cupples, L.A., Heeren, T., Coffman, G.A., Becker, C.A., Barker, T.A., Hamilton, S.K., McGuire, T.G., and Kelly, C.A.

A randomized trial of treatment options for alcohol-abusing workers. *New England Journal of Medicine* 325(11):775-782, 1991.

Walton, M.

The Deming Management Method. New York: G.P. Putnam, 1990.

Washton, A.M.

Structured outpatient treatment of alcohol vs. drug dependencies. *Recent Developments in Alcohol* 8:285-304, 1990.

Weisner C., and Schmidt, L.

Gender disparities in treatment for alcohol problems. *Journal of the American Medical Association* 268(14):1872-1876, 1992.

Yalom, I.D.

The Theory and Practice of Group Psychotherapy, Third Edition. New York: Basic Books, 1985.

Your browser does not support JavaScript

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Appendix B -- Sample IOT Program Schedules

Intensive outpatient treatment (IOT) can be adapted to several different models of treatment programs. Two such models are day treatment and evening treatment.

This appendix includes sample program schedules for a day IOT program and an evening IOT program. Also included is the evening IOT program lecture schedule.

Sample Day IOT Program Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 - 8:30	Meditation & community	Meditation & community	Meditation & community	Meditation & community; weekend preparation	Meditation & farewell to graduates
9:00 - 10:30	Group therapy	Group therapy	Group therapy	Group therapy	Group therapy
10:45 - 11:30	Assignment group	Special issues group or multifamily therapy	Orientation group	Assignment group	Assignment group
11:30 - 12:45	Lunch	Lunch	Lunch	Lunch	Lunch

12:45 - 1:45	First step evaluation or assignments	Women's or men's group	Experiential group	Leisure & stress group	Women's or men's group
2:15 - 3:30	Leisure & stress group	Step education	2nd & 3rd step group	Relapse prevention	Lecture & video
	4:00 - 5:00 Lecture & video	4:00 - 5:00 Medical aspects	4:00 - 5:30 Aftercare meeting	4:00 - 5:00 Family issues	4:00 - 5:30 Review of weekend plans
Evening	12-step meeting	12-step meeting	Community dinner & 12-step meeting on premises	Men's and women's community meeting & 12- step meeting	12-step meeting

Note: Individual counseling sessions may be scheduled from 8:00 to 9:00, Monday through Friday. Individual medical sessions may be scheduled between 8:00 and 9:00 a.m. and from 3:30 to 4:00, Monday through Friday. Attendance at one 12-step meeting per day is required during treatment.

Sample Evening IOT Program Schedule

For New Patients:

MON	5:30 - 7:30	Lectures and therapy group
WED	5:30 - 7:30	Lecture and multifamily group
THU	4:30 - 7:30	Phase One group, lecture, and therapy group
SAT	8:30 - 10:30	Activity therapy and living skills

Second Saturday of the month: Family Enrichment Day from 8:30 to 12:30.

For Family Members, Significant Others, Friends, and Support Persons:

MON	5:30 - 7:30	Lecture and family group
WED	5:30 - 7:30	Lecture and multifamily group
SAT	8:30 - 10:30	Activity therapy and living skills

Second Saturday of the month: Family Enrichment Day from 8:30 to 12:30.

For Phase Three Patients:

TUE	5:45 - 7:15
WED	9:30 - 11:00 am, and 5:45 - 7:15 pm
THU	THU 5:45 - 7:15

These patients meet one time per week. Persons completing Phase Two will choose any group that has available spaces. New groups will be formed as needed.

For Phase Three Members and All Former Patients:

Continuing Care Group: 6:00 - 7:30

This group is available, without charge, to all former patients of the program and can be used by members of Phase Three groups as additional structure during the week.

Lecture Schedule For Evening Program

A fundamental aspect of the intensive evening outpatient treatment program is education about substance abuse. This occurs during the first half-hour of each evening session. Because the education program is designed to provide the essential information for building a strong personal program of recovery, it is essential that you come to each of the sessions and arrive on time. Although you may enter the program at any time, when you complete the eight weeks, you will have attended a complete sequence of lectures and will have heard several guest speakers.

Normally, the lecture series consists of the following:

Week One:	MON:	The Disease of Addiction/Disease Progression	
	WED:	The Family Disease	
	THU:	Guest speaker	
Week Two:	MON:	Recovery is...	
	WED:	The Enabling Film	
	THU:	Recovery is...	
Week Three:	MON:	Relapse Prevention Planning	
	WED:	Family Relapse	
	THU:	An Introduction to the 12 Steps of AA and NA	
Week Four:	MON:	Medical Aspects of Addiction I	
	WED:	Alcohol and Opiates	
	THU:	Guest speaker	
Week Five:	WED:	Medical Aspects of Addiction II	
	THU:	Marijuana and Hallucinogens	
	THU:	Cross-Addiction and Healthy Alternatives	
Week Six:	MON:	Cocaine and Crack Addiction	
	WED:	Coffee, Cigarettes, Nutrition, and Recovery	
	THU:	Guest speaker	
Week Seven:	MON:	The First Step: Surrender	
	WED:	Sex and Relationships	

	THU:	Spirituality
Week Eight:	MON:	Feelings and Addiction
	WED:	Anger
	THU:	Shame and Guilt

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Appendix C -- Federal Resource Panel

John Ambrose

Vice President of Public Affairs

National Mental Health Association

Jim Brennan

Staff Associate

National Association of Social Workers

William Butynski, Ph.D.

Executive Director

National Association of State Alcohol and Drug Abuse Directors

James Callahan, D.P.A.

Executive Vice President

American Society of Addiction Medicine

Sandra M. Clunies, M.S., N.C.A.D.C.

Government Project Officer

Quality Assurance and Evaluation Branch

Division of State Programs

Center for Substance Abuse Treatment

Dorynne Czechowicz, M.D.

Associate Director

Medical and Professional Affairs

Division of Clinical Research

National Institute on Drug Abuse

Walter L. Faggett, M.D.

Capital Area Health Services

Washington, D.C.

John Gregich

Acting Assistant Deputy for Treatment

Office for National Drug Control Policy

Executive Office of the President

Tamiko Hamiel

Association Coordinator

Drug and Alcohol Nursing Association

Ruth H. Carlsen Kahn, D.N.Sc.

Health Manpower Education Specialist

Bureau of Health Professions

Health Resources and Services Administration

Linda Kaplan

Executive Director

National Association of Alcoholism and Drug Abuse

David C. Lewis, M.D.

Association for Medical Education and Research in Substance Abuse

Brown University

Providence, Rhode Island

Cherry Lowman

Health Scientist Administrator

Treatment Research Branch

Clinical and Prevention Research

National Institute on Alcohol Abuse and Alcoholism

Robert Lubran

Senior Advisor for Quality Assurance

Quality Assurance and Evaluation Branch

Division of State Programs

Center for Substance Abuse Treatment

Anna Marsh, Ph.D.

Associate Director for Evaluation

Office of Applied Studies

Center for Substance Abuse Treatment

Paul Nagy, M.S., C.S.A.C.

Director Counseling

Duke Alcohol and Addictions Program

Clinical Associate

Department of Psychiatry

Duke University Medical Center

Durham, North Carolina

Cecelia Willis, M.D.

National Black Alcoholism Council

Your browser does not support JavaScript

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

Appendix D -- Field Reviewers

Bob Anderson

Director

Criminal Justice Programs

National Association of State Alcohol and Drug Abuse Directors

Doug Baker, C.S.A.C.

Assistant Section Chief

Alcohol and Drug Abuse Section

North Carolina Department of Human Resources

Richard J. Bast

Public Health Advisor

Center for Substance Abuse Treatment

David Beaman, Ph.D.

Director

Substance Abuse and Prevention Services

Planning District 19

Community Services

Board of Substance Abuse Services

Petersburg, Virginia

J. B. Bixler

Executive Director

Association of Community Mental Health Authorities of Illinois

Springfield, Illinois

L. Worth Bolton, M.S.W., A.C.S.W.

Program Director

Westhaven Outpatient Treatment Programs

Raleigh, North Carolina

Bill B. Burnett, M.Ed.

Director

Treatment and Intervention

South Carolina Commission on Alcohol and Drug Abuse

Bruce Carruth, Ph.D., L.C.S.W.

Little Rock Psychotherapy Group

Little Rock, Arkansas

Lloyd Crawford, Ph.D.

Administrator

Plumas County Alcohol and Drug Program

Quincy, California

Dorynne Czechowicz, M.D.

Associate Director for Medical and Professional Affairs

Division of Clinical Research

National Institute on Drug Abuse

Doris Derrington

Consultant

Alcohol and Drug Abuse Services

Topeka, Kansas

Jim Dyson

Director

Addiction Recovery Center

Rapid City Regional Hospital

Rapid City, South Dakota

Garland Ferguson

Assistant Director

Arkansas Division of Alcohol and Drug Prevention

William J. Filstead, Ph.D.

Quality Measurements, Inc.

Arlington Heights, Illinois

Robert F. Forman, Ph.D.

Executive Director

Rehab After Work

King of Prussia, Pennsylvania

Peter Frantantuono, Jr., M.A., A.C.D.P.

Executive Director

Counseling and Intervention Services

Rhode Island Substance Abuse Advisory Council

Warwick, Rhode Island

Mark Galizio, Ph.D.

Professor of Psychology

Department of Psychology

University of North Carolina, Wilmington

Anne Geller, M.D.

President

American Society of Addiction Medicine

Deborah Goldman, Ph.D.

Smithers Outpatient Department

St. Luke's-Roosevelt Hospital

New York, New York

Terence T. Gorski

President

Cenaps Corporation

Homewood, Illinois

Bruce Hart, M.S., C.A.D.A.C.

Clinical Coordinator

Starting Now Intensive Outpatient Treatment Program

Brattleboro, Vermont

Jack Harville

President

Dilworth Center for Chemical Dependency

Charlotte, North Carolina

Bohdan Hrynewych, A.C.S.W.

Program Coordinator

Duke Alcoholism and Addictions Program

Duke University Medical Center

Durham, North Carolina

Lotty Inselberg, Ph.D., R.N., C.A.R.N.

North Woodmere, New York

George Jacobson, Ph.D.

Milwaukee Psychiatric Hospital

Wauwatosa, Wisconsin

Marco E. Jacome, C.S.A.D.C., C.E.A.P., N.C.A.C. II

Executive Director

Healthcare Alternative Systems, Inc.

Chicago, Illinois

Gary Q. Jorgensen, Ph.D.

Director

Drug and Alcohol Abuse Clinic

School of Medicine

University of Utah

Ruth H. Carlsen Kahn, D.N.Sc.

Health Manpower Education Specialist

Division of Medicine

Bureau of Health Professions

Health Resources and Services Administration

Linda Kaplan, M.A., C.A.E.

Executive Director

National Association of Alcoholism and Drug Abuse

Christine L. Kasser, M.D.

Medical Director
Baptist Recovery Center
Memphis, Tennessee

Julian Keith, M.D.

Section Chief
Alcohol and Drug Abuse Section
North Carolina Department of Human Resources

George Kolodner, M.D.

Medical Director
Kolmac Clinic
Silver Spring, Maryland

Tom Kosten, M.D.

Division of Substance Abuse
Yale University
New Haven, Connecticut

Joel Kostin, Ph.D.

Regional Director
Achievement and Guidance Center of America
Chapel Hill, North Carolina

Donald P. Loker, N.C.A.C. II, C.A.P.

1st Step of Sarasota, Inc.
Sarasota, Florida

Bruce Lorenz, N.C.A.C. II, C.A.D.C., C.E.A.P.

Delaware Drinking Driver Programs, Inc.
Dover, Delaware

Mary E. McCaul, Ph.D.

Associate Professor

Comprehensive Women's Center

Francis Scott Key Medical Center

Johns Hopkins University School of Medicine

Baltimore, Maryland

David Mee-Lee, M.D.

Medical Director

Castle Medical Center

Honolulu, Hawaii

Michael M. Miller, M.D.

Meriter Hospital, Inc./New Start

Madison, Wisconsin

Tony Mulvihill

Director

Alcohol and Drug Council of North Carolina

Durham, North Carolina

Madeline A. Naegle, Ph.D., R.N., F.A.A.N.

Division of Nursing

School of Education

New York University

New York, New York

Paul D. Nagy, M.S., C.S.A.C.

Director

Substance Abuse Counseling

Duke University Medical Center

Durham, North Carolina

Steven Newman, Ed.D.

Director

Substance Abuse Services

Mecklenburg Mental Health, Developmental Disability, and Substance Abuse Services

Charlotte, North Carolina

Jewell Oates, Ph.D.

Executive Director

The Women's Treatment Center

Chicago, Illinois

Larry G. Osmonson, N.C.A.C. II, C.A.P., C.T.R.T.

President

National Association of Alcoholism and Drug Abuse Counselors

Vincent J. Patti, C.S.W.

Psychotherapist

New York, New York

Larry Petersen, L.C.S.W.

Salt Lake County Division of Substance Abuse Services

Salt Lake City, Utah

Edward Ravine, M.A., C.R.A.D.C.

Assistant Division Director

Mental Health Division

Lake County Health Department

Waukegan, Illinois

Fannie Robertson, R.N., M.S., C.D.

Commission on Public Health of the District of Columbia

Virginia Ryan, Ph.D.

Principal Investigator

Self Help Addiction Rehabilitation

Detroit, Michigan

Irv Shandler, Ph.D.

President/CEO

Diagnostic and Rehabilitation Center

Philadelphia, Pennsylvania

John Shields

Director

Medicorp Recovery Network of Winston-Salem

Winston-Salem, North Carolina

Michael O. Smith, M.D., D.Ac.

Director

Substance Abuse Division

Lincoln Hospital

Bronx, New York

Phillip Spivey, Ph.D.

Director

Outpatient Services

Smithers Alcoholism Treatment and Training Center

St. Luke's-Roosevelt Hospital

New York, New York

Teresa Staley, M.A., N.C.A.C. II, C.A.C. II

Clinical Director

Clitheroe Center

Anchorage, Alaska

Donald Storms, C.A.C., C.A.D.A.C., C.H.I.V.C.

Project Coordinator

Bureau of HIV Program Services

New York City Department of Health

Barbara Warren, Psy.D., C.A.C.

Director

Mental Health and Social Services

Lesbian and Gay Community Service Center

New York, New York

Arnold M. Washton, Ph.D.

Director

The Washton Institute on Addictions

New York, New York

Kathy Leigh Willis, C.E.A.P., N.C.A.C. II,

President

California Association of Alcoholism and Drug Abuse Counselors

Intensive Outpatient Treatment for Alcohol and Other Drug Abuse

Treatment Improvement Protocol (TIP) Series

8

[Exhibits]

Exhibit 2-1 DSM-IV Diagnostic Criteria for Substance Dependence

DSM-IV Diagnostic Criteria for Substance Dependence

The DSM-IV describes substance dependence as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - b. Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for the substance.
 - b. The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. There is persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain or use the substance, or to recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that

is likely to have been caused or exacerbated by the substance.

(Adapted with permission from the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Washington, D.C.: American Psychiatric Association, 1994.)

Exhibit 2-2 American Society of Addiction Medicine Adult Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders

American Society of Addiction Medicine Adult Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders				
Levels of Care	Level I Outpatient Treatment	Level II Intensive Outpatient Treatment	Level III Medically Monitored Intensive Inpatient Treatment	Level IV Medically Managed Intensive Inpatient Treatment
Criteria Dimensions				
1 Acute Intoxication and/or Withdrawal Potential	No withdrawal risk.	Minimal withdrawal risk.	Severe withdrawal risk but manageable in Level III.	Severe withdrawal risk.
2 Biomedical Conditions and Complications	None or very stable.	None or nondistracting from addiction treatment and manageable in Level II.	Requires medical monitoring but not intensive treatment.	Requires 24- hour medical, nursing care.
3 Emotional and Behavioral Conditions and Complications	None or very stable.	Mild severity with potential to distract from recovery.	Moderate severity needing a 24- hour structured setting.	Severe problems requiring 24-hour psychiatric care with concomitant addiction

				treatment.
4 Treatment Acceptance and Resistance	Willing to cooperate but needs motivating and monitoring strategies.	Resistance high enough to require structured program, but not so high as to render outpatient treatment ineffective.	Resistance high despite negative consequences and needs intensive motivating strategies in 24-hour structure.	Problems in this dimension do not qualify patient for Level IV treatment.
5 Relapse Potential	Able to maintain abstinence and recovery goals with minimal support.	Intensification of addiction symptoms and high likelihood of relapse without close monitoring and support.	Unable to control use despite active participation in less intensive care and needs 24- hour structure.	Problems in this dimension do not qualify patient for Level IV treatment.
6 Recovery Environment	Supportive recovery environment and/or patient has skills to cope.	Environment unsupportive but with structure or support, the patient can cope.	Environment dangerous for recovery necessitating removal from the environment; logistical impediments to outpatient treatment.	Problems in this dimension do not qualify patient for Level IV treatment.

Exhibit 4-1 Cultural Sensitivity Training Materials and Resources

Cultural Sensitivity Training Materials and Resources

Materials

Sue, D.W., and Sue, D. *Counseling the Culturally Different: Theory and Practice, Second Edition*. New York: John Wiley & Sons, 1990.

Finnegan, D.G., and McNally, E.B. *Dual Identities: Counseling Chemically Dependent Gay Men and Lesbians*. Center City, Minnesota: Hazelden Educational Materials, 1987.

Goodchilds, J.D., ed. *Psychological Perspectives on Human Diversity in America*. Washington, D.C.: American Psychological Association, 1991.

Hidalgo, H., Peterson, T.L., and Woodman, N.J., eds. *Lesbian and Gay Issues: A Resource Manual for Social Workers*. Silver Spring, Maryland: National Association of Social Workers, Inc., 1985.

Weinstein, D.L., ed. *Lesbians and Gay Men: Chemical Dependency Treatment Issues*. Binghamton, New York: Haworth Press, Inc., 1992.

Agency

Technical Assistance Center, Institute on Black Chemical Abuse, 2616 Nicollet Avenue, Minneapolis, MN 55408, 612-871-7878.

Exhibit 5-1 Selected Comparisons of Recovery and Mental Health Models

Selected Comparisons of Recovery and Mental Health Models	
<u>Recovery Model</u>	<u>Mental Health Model</u>
Disease process	Syndrome concept
Biopsychosocial/spiritual factors	Biopsychosocial factors and some attention to philosophical issues
Chronic condition	Chronic condition of many major disorders
Relapse issues	Relapse issues
Genetic/physiological component	Genetic/physiological component in many disorders
Chemical use primary	Psychiatric disorder primary
Out of control	Ineffective coping
Denial	Poor insight
Despair	Demoralization
Family issues	
Social stigma	

Abstinence early goal	Family issues
Recovery long-term goal	Social stigma
Powerlessness	Stability early goal
No use of mood altering chemicals	Rehabilitation long-term goal
Education about illness	Empowerment
Halfway houses, ALANO clubs	Psychotropic medications used
Sponsors	Education about illness
AA, Al-Anon, self-help groups	Group homes, day treatment
Concrete action	Case manager/therapist
Self-examination and acceptance	Support groups
Label self as alcoholic/addict	Behavior change
Practice of communication, social skills	Awareness and insight
Slogans, stories, affirmations	See self as whole person with a disorder
Stepwork	Practice of communication, social skills
Use of spiritual concepts	Positive self-talk, imagery
Family therapy	Psychotherapy
Group and individual work	Use of existential, transpersonal concepts
Continuum of care	Family therapy
Nutrition, exercise, growth as value	Group and individual work
	Continuum of care
	Wellness concepts

Reprinted with permission from Evans, K., and Sullivan, J.M. *Dual Diagnosis: Counseling the Mentally Ill Substance Abuser*. New York: Guilford Press, 1990.

Exhibit 6-1 Intensive Outpatient Treatment (IOT) Programs: Sample Cost Data

Intensive Outpatient Treatment (IOT) Programs: Sample Cost Data						
	1	2	3	4	5	6
Program Type						
Evening	X	X	X	X	X	X
Day	X	X		X	X	
Partial				X		X

hospitalization						
Other	Aftercare				Adolescent ²	
Region	NE	Midwest	South	NE	South	NE
Locale	Urban	Urban	Small metro.	Urban	Urban/rural	Urban/suburban
Institutional Status						
Private for-profit						X
Private nonprofit	X	X	X	X	X	
Public					X	
Payer Mix (by %)						
Insurance/managed care	45%	X ¹	75%	1%		50%
Medicaid		X ¹		68%	5%	
Medicare		X ¹	3%	2%		
Self-pay	5%	X ¹	22%	1%		10%
HMO contract	50%	Xm.nih.gov/hq/Hquest/db/local.tip.tip8/screen/Browse/s/51423/cmd/HF/action/GetText?IHR=e6-1f1 > ¹				40%
State grant/purchase		X ¹		28%	95%	

se of care						
Capacity (at 100%)						
Daily	150 ³	64	24	24 Full ⁴ 20 Parti al ⁴	N/A ⁵	48
Weekly	300 ³	320	24	24 Full ⁴ 20 Parti al ⁴	N/A ⁵	100 (240 in aftercar e)
Salary Ranges						
Administrato rs/managers	\$38, 000 ⁶ to 50,0 00	\$30,000 to 52,000	\$35, 000 to 50,0 00	\$26,0 00 to 67,00 0	N/A	\$45,000
Physicians	\$70/ hour to 100/ hour	\$30,000 to 50,000	\$20, 000 ⁷ to 26,0 00	\$26.5 0/ hour	N/A	\$36,000 for 1/3 time
Social workers	\$28, 000 to 35,0 00	\$30,000 to 37,000	\$28, 000 to 35,0 00	\$24,7 00 ⁸ to 28,20 0 ⁸	N/A	\$30,000 to 45,000
Psychologists	\$30, 000 to 40,0 00	N/A	\$35, 000 to 45,0 00	Only progr am direc tor	N/A	N/A

	FY 91-92	FY 91-92
Program 1	\$1,023,679	\$1,157,208
Program 2	\$2,033,287	\$2,025,504
Program 3	\$267,440	\$364,726
Program 4	\$187,106 Full day \$82,756 Partial day	\$254,561 Full day \$111,832 Partial day
Program 5	\$2,623,332	N/A
Program 6	\$1,120,000	\$1,140,000

¹ Payer mix includes all categories; percentages not provided.

² Ten adult programs and four adolescent programs.

³ In total of three centers

⁴ Full day = 2-week program; Partial day = 4-week progra

⁵ 19 adult, 4 adolescent programs with >3,000 patients

⁶ Executive director's salary is in a management contract and is \$70,000 for management.

⁷ Part-time, 10 hours

⁸ Master's-level substance abuse therapist; various disciplines

⁹ Bachelor's-level clinician with AOD credentials

¹⁰ Includes center directors and marketing budget. Directors provide some direct service.

Exhibit 7-1 Consent for the Release of Confidential Information

<p>Consent for the Release of Confidential Information</p> <p>I, _____, authorize (Name of patient)</p> <p>_____ (Name or general designation of program making disclosure)</p> <p>to disclose to _____ (Name of person or organization to which disclosure is to be made)</p> <p>the following information: _____ (Nature of the information, as limited as possible)</p> <p>_____</p> <p>_____</p>

The purpose of the disclosure authorized herein is to:

(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

Dated: _____

(Signature of participant)

(Signature of parent, guardian, or
authorized representative when required)

Exhibit 7-2 Prohibition on Redisclosing Information Concerning AOD Abuse Treatment Patients

Prohibition on Redisclosing Information Concerning AOD Abuse Treatment Patients

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The

Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Exhibit 7-3 Consent for the Release of Confidential Information: Criminal Justice System Referral

Consent for the Release of Confidential Information: Criminal Justice System Referral

I, _____, hereby consent to
(Name of defendant)
communication between _____ and
(treatment program)

(Court, probation, parole, and/or other referring agency)
the following information: _____
(Nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agenc(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

I understand that this consent will remain in effect and cannot be revoked by me until: _____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or _____

(other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and that recipients of this information may redisclose it only in connection with their official duties.

(Date) (Signature of defendant/patient)

(Signature of parent, guardian, or
authorized representative if required)

Exhibit 7-4 Qualified Service Organization Agreement

Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____

(Name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide the following services:

(Nature of services to be provided)

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the patients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2: and
2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the Federal confidentiality regulations, 42 CFR Part 2.

Executed this _____ day of _____, 199__.

President
XYZ Service Center
(Address)

Program Director
(Name of Program)
(Address)